From DSM-IV-TR to DSM-5

What Specifically is Changing?

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Disclosure

Objectives

Upon completion of this workshop, participants should increase their ability to effectively care for clients by being able to:

1. Summarize the history of those aspects of diagnostic classification that led directly to the development of the DSM
2. Summarize the DSM revision process.
3. Describe the multiphase effort that provided an enhanced research base in support of the DSM-5.
4. Describe the specific changes in diagnostic criteria of mental disorders, from DSM-IV-TR to DSM-5; as well as implement these skills in their daily practice.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

This course is for clinicians who are already familiar with DSM-IV-TR, its content, and its use.

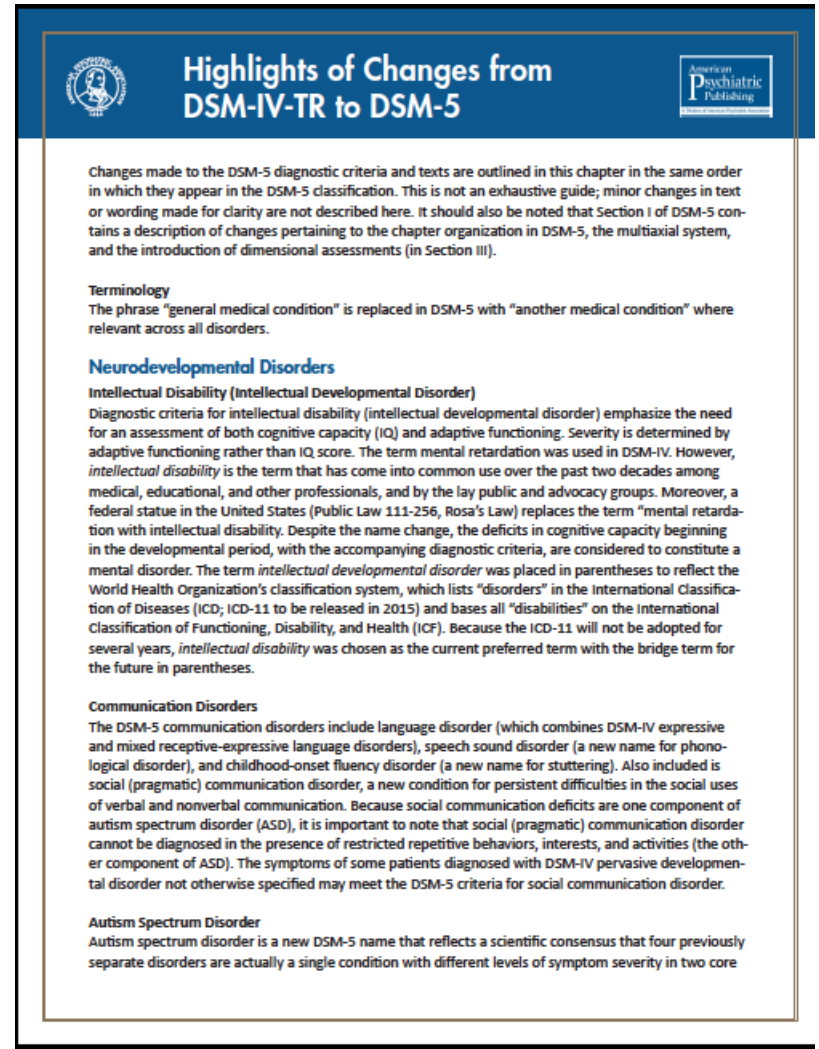
This presentation is solely to facilitate transition from DSM-IV-TR to DSM-5 and is not intended to be a basic course on DSM-5.

Agenda

9:00 am	Introduction to the Workshop
9:15 am	History of Diagnostic Classification and Development of the DSM
10:00 am	Overall Changes: From DSM-IV-TR to DSM-5
10:15 am	BREAK
10:30 am	Specific Changes: Neurodevelopmental Disorders
11:00 am	Specific Changes: Schizophrenia Spectrum and Other Psychotic Disorders
11:30 am	Specific Changes: Bipolar and Depressive Disorders
12:00 pm	LUNCH
1:00 pm	Specific Changes: Anxiety, Obsessive-Compulsive, Trauma-Related, and Dissociative Disorder
1:45 pm	Specific Changes: Somatic Symptom, Eating, Sleep, and other Disorders
2:15 pm	BREAK
2:30 pm	Specific Changes: Impulse Control, Substance Use, Neurocognitive, and Personality Disorders
3:15 pm	Codes Issues and Insurance Implications
3:45 pm	Q & A
4:00 pm	ADJOURNMENT

Highlights of Changes from DSM-IV-TR to DSM-5

http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf



Highlights of Changes from DSM-IV-TR to DSM-5

Changes made to the DSM-5 diagnostic criteria and texts are outlined in this chapter in the same order in which they appear in the DSM-5 classification. This is not an exhaustive guide; minor changes in text or wording made for clarity are not described here. It should also be noted that Section I of DSM-5 contains a description of changes pertaining to the chapter organization in DSM-5, the multiaxial system, and the introduction of dimensional assessments (in Section III).

Terminology
The phrase "general medical condition" is replaced in DSM-5 with "another medical condition" where relevant across all disorders.

Neurodevelopmental Disorders

Intellectual Disability (Intellectual Developmental Disorder)
Diagnostic criteria for intellectual disability (intellectual developmental disorder) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score. The term mental retardation was used in DSM-IV. However, *intellectual disability* is the term that has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups. Moreover, a federal statue in the United States (Public Law 111-256, Rosa's Law) replaces the term "mental retardation with intellectual disability. Despite the name change, the deficits in cognitive capacity beginning in the developmental period, with the accompanying diagnostic criteria, are considered to constitute a mental disorder. The term *intellectual developmental disorder* was placed in parentheses to reflect the World Health Organization's classification system, which lists "disorders" in the International Classification of Diseases (ICD; ICD-11 to be released in 2015) and bases all "disabilities" on the International Classification of Functioning, Disability, and Health (ICF). Because the ICD-11 will not be adopted for several years, *intellectual disability* was chosen as the current preferred term with the bridge term for the future in parentheses.

Communication Disorders
The DSM-5 communication disorders include language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders), speech sound disorder (a new name for phonological disorder), and childhood-onset fluency disorder (a new name for stuttering). Also included is social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication. Because social communication deficits are one component of autism spectrum disorder (ASD), it is important to note that social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviors, interests, and activities (the other component of ASD). The symptoms of some patients diagnosed with DSM-IV pervasive developmental disorder not otherwise specified may meet the DSM-5 criteria for social communication disorder.

Autism Spectrum Disorder
Autism spectrum disorder is a new DSM-5 name that reflects a scientific consensus that four previously separate disorders are actually a single condition with different levels of symptom severity in two core

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What Specifically is Changing?

History of Diagnostic Classification and Development of the DSM

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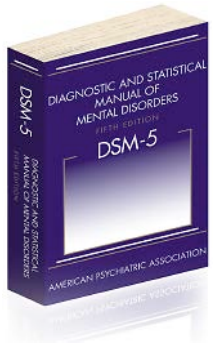


DSM-5

" It is the largest project in which most of us have ever been involved: review of several decades of scientific research and 10 years of international conferences and deliberation, with the involvement of more than 900 experts from this country and abroad, including clinicians and researchers in psychiatry, psychology, statistics, epidemiology, neurology, pediatrics, social work, and other disciplines and specialties."

David Kupfer, MD, chair of the DSM-5 Task Force, originally appeared on Medscape on June 1, 2012. Available at http://www.medscape.com/viewarticle/764735. Accessed November 28, 2012

DSM

- Five major revisions since it was first published in 1952, gradually including more disorders.
- The last major revision, until DSM-5, was the DSM-IV published in 1994, although a "text revision" was produced in 2000.
- The DSM-5 was released in May 2013.

The Diagnostic and Statistical Manual of Mental Disorders

Impact of the DSMs (1)

1. **Access to care and treatment**. DSM "*is the cornerstone in the edifice of mental health care*" [Sadler, 2006].
2. **Access to entitlements**. Defines the responsibilities of public agencies accountable for the psychiatrically ill. Reimbursements are administered on the basis of the DSM [in an overlap with ICDs].
3. **Approved treatments**
4. **Research**

Impact of the DSMs (2)

5. **Education.** The teaching of psychopathology in the United States and many other countries follows the DSM.
6. **Legal and criminal decisions.** Despite disclaimer within the DSMs, the DSMs are often used to answer legal questions.
7. **Society's concept of mental illness, of normality.** Many DSM terms have become part of the American discourse.
8. **Defines psychiatry**. Defines the scope of professional skills of psychiatrists.

History of DSM

- The initial impetus for developing a classification of mental disorders in the US was the need to collect statistical information.
- The first official attempt was the 1840 census which used a single category, "idiocy/insanity".

History of DSM

The 1880 census distinguished among seven categories:

1. Mania
2. Melancholia
3. Monomania
4. Paresis
5. Dementia
6. Dipsomania
7. Epilepsy

History of DSM

Statistical Manual for the Use of Institutions for the Insane (1917)

- Developed by the Committee on Statistics [what is now known as the APA] and the National Commission on Mental Hygiene.
- Included 22 diagnoses

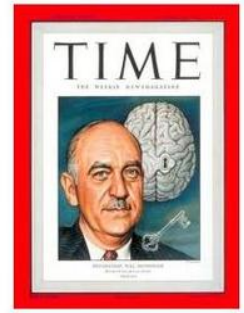
History of DSM

Standard Classified Nomenclature of Disease (1933)

- APA, along with the New York Academy of Medicine, provided the psychiatric nomenclature subsection of this US medical guide. Commonly referred to as the "Standard".

WORLD WAR II AND MEDICAL 203

- A committee headed by psychiatrist and brigadier general William C. Menninger developed a new classification scheme called **Medical 203**, issued in 1943 as a "War Department Technical Bulletin" under the auspices of the Office of the Surgeon General.
- Eventually adopted by all Armed Forces
  - Assorted modifications were introduced into many clinics and hospitals by psychiatrists returning from military duty.
- VA also adopted a slightly modified version of Medical 203.



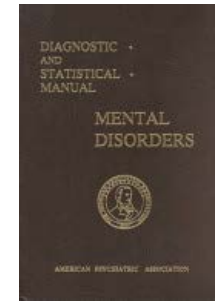
ICD-6 and Start of DSM

- In 1949, the WHO published the sixth revision of the ICD which included a section on mental disorders for the first time.
- An APA Committee on Nomenclature and Statistics was empowered to develop a version specifically for use in the US, to standardize the diverse and confused usage of different documents.

World Health Organization

DSM-I 1952

- In 1950 the APA Committee on Nomenclature and Statistics undertook a review.
- The Committee circulated an adaptation of Medical 203, the VA system, and the Standard's Nomenclature, to approximately 500 APA members [approx. 10% of APA members]. 46% replied, of which 93% approved.
- After some further revisions, the Diagnostic and Statistical Manual of Mental Disorders was approved in 1951 and published in 1952
- DSM-I was 130 pages long and listed 106 mental disorders.

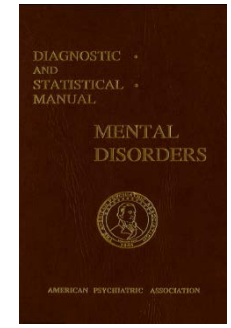


- Described terms, for example, Schizophrenic Reactions was defined as:

  "*It represents a group of psychotic disorders characterized by fundamental disturbances in reality relationships and concept formations, with affective, behavioral, and intellectual disturbances in varying degrees and mixtures. The disorders are marked by strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in stream of thought, regressive behavior, and in some, a tendency to deterioration.*"

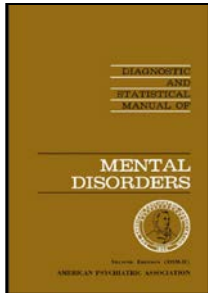
- Seventy terms used "Reaction," e.g., Schizophrenic Reaction. This included reaction to internal conflict.

DSM-I 1952



DSM-II, 1968

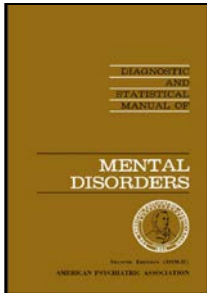
- Published in 1968. Listed 182 disorders/134 pages long.
- Similar to the DSM-I.
- The term “reaction” was dropped but the term “neurosis” was retained.
- Symptoms were not specified in detail for specific disorders.
- Many were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis.



Took an atheoretical position:

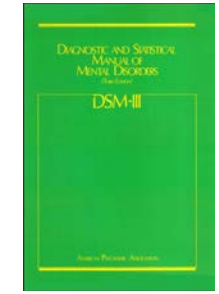
> *"In the case of diagnostic categories about which there is current controversy concerning the disorder's nature or cause, the Committee has attempted to select terms which it thought would least bind the judgment of the user. … Inevitably some users of the Manual will read into it some general view of the nature of mental disorders. The Committee can only aver that such interpretations are, in fact, unjustified."*

DSM-II, 1968



DSM-III 1980

- In 1974, the decision to create a new revision of the DSM was made, and Robert Spitzer was selected as chairman of the task force.
- The initial impetus was to
  - Make the DSM nomenclature consistent with the ICD
  - Improve the uniformity of psychiatric diagnosis in the wake of a number of critiques, including the famous Rosenhan experiment.
  - Standardize diagnostic practices within the US and with other countries.
- The establishment of these criteria was also an attempt to facilitate the pharmaceutical regulatory process.



On Being Sane in Insane Places

D. L. Rosenhan

If sanity and insanity exist, how shall we know them?

SCIENCE, VOL. 179
19 JANUARY 1973

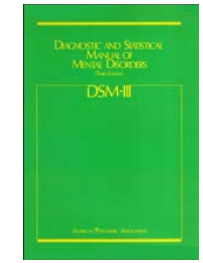
The Rosenhan experiment

- An experiment into the validity of psychiatric diagnosis conducted by David Rosenhan in 1972. The study consisted of two parts.
  1. using healthy associates or "pseudo-patients," who briefly simulated auditory hallucinations in an attempt to gain admission to 12 different psychiatric hospitals in five different states in various locations in the United States.
  2. asking staff at a psychiatric hospital to detect non-existent "fake" patients.

- In the first case hospital staff failed to detect a single pseudopatient.
- In the second the staff falsely identified large numbers of genuine patients as impostors.

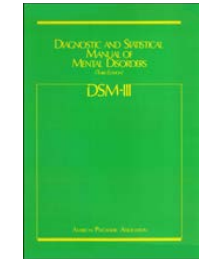
- Many work groups were established of which Spitzer was a member of each.
- A draft edition was available to many and reactions were encouraged and addressed by the work groups.
- Many were invited to provide input; probably the total eventually exceeded a thousand APA members.
- APA Assembly was part of the approval process.

DSM-III 1980



- The criteria adopted for many of the mental disorders were taken from the Research Diagnostic Criteria (RDC) and Feighner Criteria.
  - Developed by a group of research-orientated psychiatrists based primarily at Washington University and the New York State Psychiatric Institute.
- Other criteria, and potential new categories of disorder, were established by a consensus during meetings of the committee, as chaired by Spitzer.
- A key aim was for criteria to be descriptive rather than assumptions of etiology.
- A new "multiaxial" system attempted to yield a picture more amenable to a statistical population census, rather than just a simple diagnosis.

DSM-III 1980

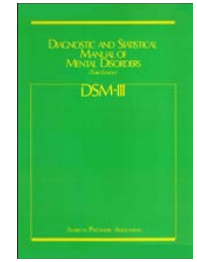


Feighner Criteria

- Diagnostic criteria for use in psychiatry research.
- First presented in a scientific paper published in 1972 of which John Feighner was the principal author.
- Fourteen conditions were defined including primary affective disorders, schizophrenia, anxiety neurosis, and antisocial personality disorder.
- The criteria were expanded in the publication of the Research Diagnostic Criteria (RDC) on which many of the criteria of DSM-III were based.

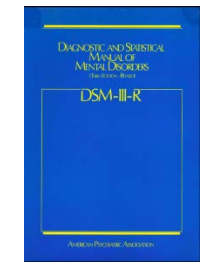
- The first draft prepared within a year.
- Many new categories of disorder were introduced.
- Field trials sponsored by the NIMH were conducted between 1977 and 1979 to test the reliability of the new diagnoses.
- Published in 1980
  - 494 pages and 265 diagnostic categories.
- Rapidly came into widespread international use by multiple stakeholders and has been termed a revolution or transformation in psychiatry.

DSM-III 1980



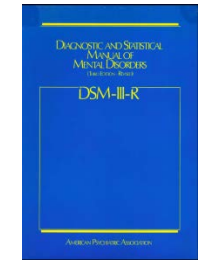
DSM-III-R 1987

- Published in 1987 under the direction of Spitzer.
- 292 diagnoses/567 pages
- Categories were renamed, reorganized, and significant changes in criteria were made.
- Six categories were deleted while others were added.
- Removed “Egodystonic Homosexuality”
- Controversial diagnoses such as pre-menstrual dysphoric disorder and Masochistic Personality Disorder were considered and discarded.



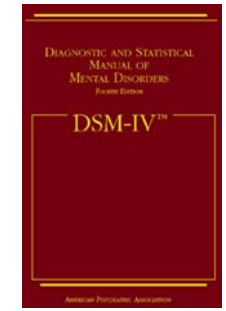
- Established a category of *Disorders to be Studied*
- Contained a symptom index
- 45% changes in nomenclature
- DSM-III-R contained 292 diagnoses and was 567 pages long

DSM-III-R 1987



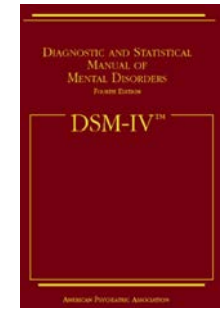
- The task force was chaired by Allen Frances.
- Much like DSM-III, greater international involvement and more involvement of other mental health organizations.
- The work groups conducted a three step process:
    1. Each group conducted an extensive literature review of their diagnoses.
    2. Then they requested data from researchers, conducting analyses to determine which criteria required change, with instructions to be conservative.
    3. Finally, they conducted multicenter field trials relating diagnoses to clinical practice.

DSM-IV 1994



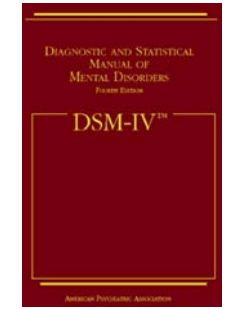
- Published In 1994.
- 297 disorders/ 886 pages.
- Modifications of some criteria sets,
  - Removed “organic” as a concept and replaced with conditions related to “General Medical Conditions”
  - Removed Self-defeating and Sadistic Personality Disorder from Disorders to be Studied
  - Removed symptom index
  - Allowed non-Axial system

DSM-IV 1994



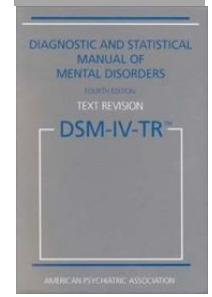
- A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause "***clinically significant distress or impairment in social, occupational, or other important areas of functioning***".

DSM-IV 1994



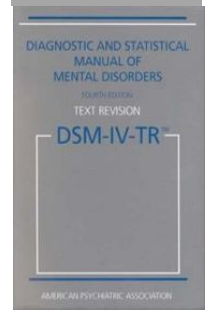
- Virtually no changes in criteria sets or nomenclature, but text was improved considerably.
  - Process. With switch in Chair from Frances to First, used DSM-IV structure and Task Force members to rapidly make text accurate and current.
  - No massive involvement of APA membership was necessary.

DSM-IV-TR 2000

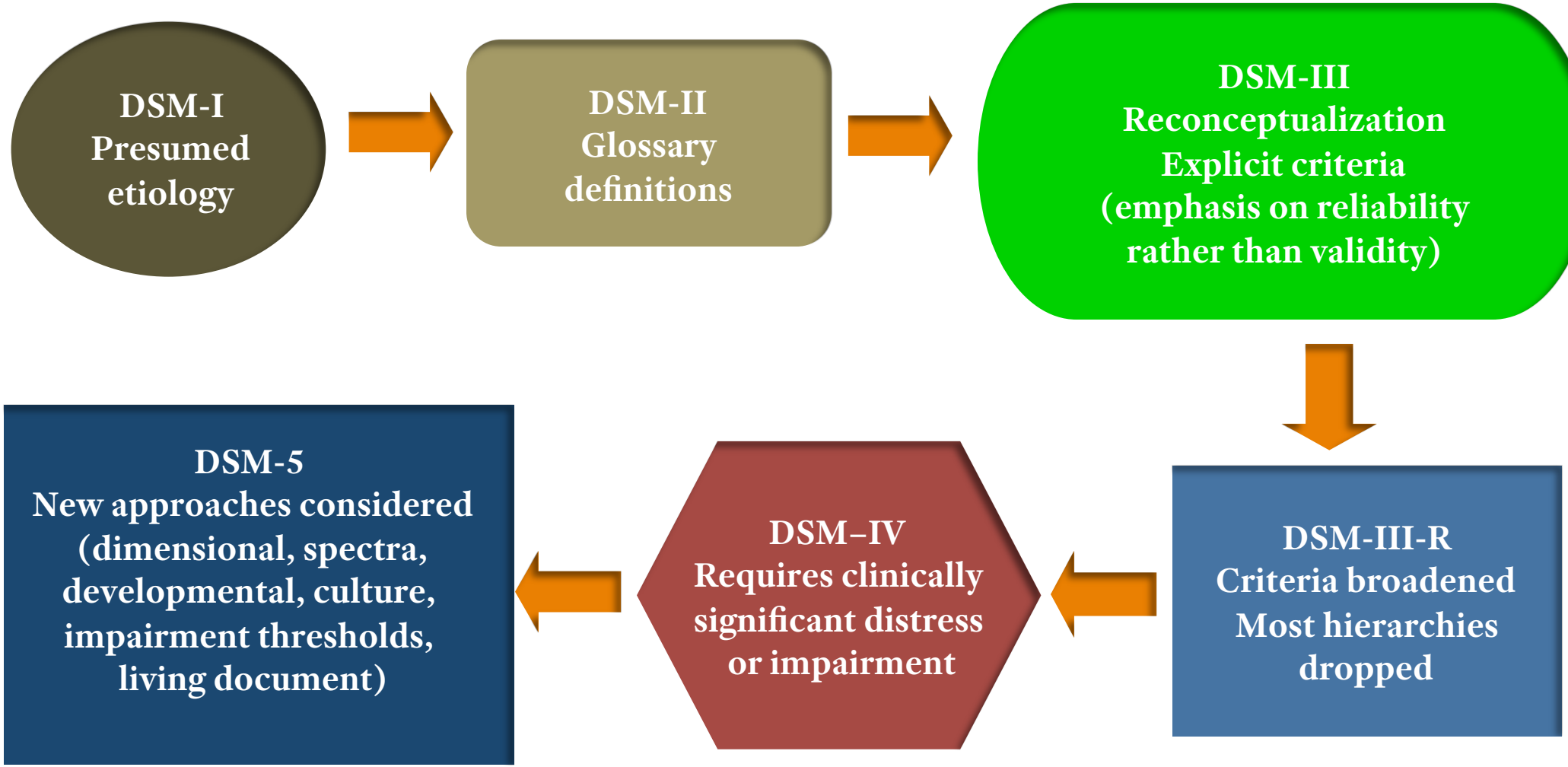


- A "Text Revision“ published in 2000.
- The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged.
- Text improved considerably.
  - The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes in order to maintain consistency with the ICD.

DSM-IV-TR 2000



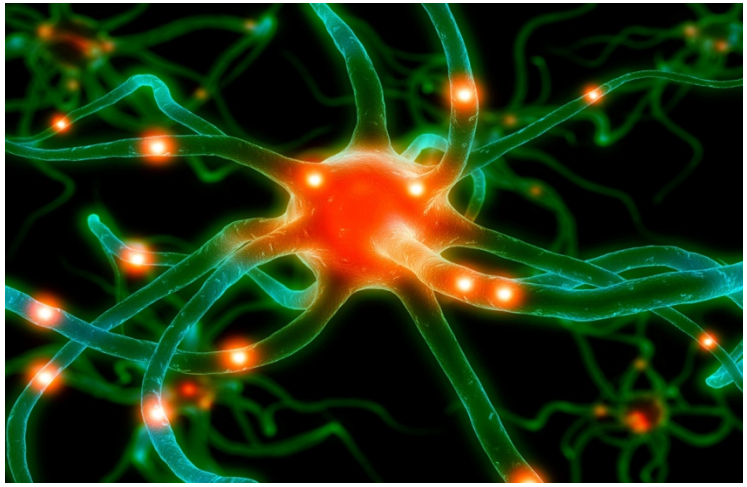
Conceptual Development of DSM



2nd Golden Era of Neuroscience

"The dream of understanding mental phenomena in terms of neural mechanisms now lies within our reach."

-- Andreasen and Black, 1995



Perceived Shortcomings in DSM-IV

- Categorical diagnostic system
- Reliability ≠ Validity
- Measureable criteria tell little about severity and disability
- Multiaxial system did not capture the quantitative components of a categorical diagnostic system

David Kupfer. Overview of DSM-V. Presented at the 2009 Annual Meeting of the American College of Psychiatrists. Tucson Arizona, February 24- March 1, 2009

Perceived Shortcomings in DSM-IV (continued)

- High rates of comorbidity
- High use of NOS category
- Treatment non-specificity
- Inability to find laboratory markers/tests
- DSM is starting to hinder research progress

David Kupfer. Overview of DSM-V. Presented at the 2009 Annual Meeting of the American College of Psychiatrists. Tucson Arizona, February 24- March 1, 2009

- Momentous advances in genetics and brain imaging since publication of DSM-IV in 1994 have generated optimism that an improved understanding of the neurobiologic underpinnings of psychiatric disorders might lead to a paradigm shift from the current descriptive classification system to a more scientific etiopathophysiological system similar to that used by other medical specialties.

Kupfer DJ, First MB, Regier DA. eds. A research agenda for DSM-V. Washington, DC: American Psychiatric Association; 2002.

Revision Principles

- The highest priority in modifying DSM-5 should be optimizing clinical utility
- Recommendations should be guided by research evidence
- Continuity with previous editions should be maintained
- Unlike in DSM-IV, there will be no *a priori* constraints on the degree of change between DSM-IV and DSM-V

David Kupfer. Overview of DSM-V. Presented at the 2009 Annual Meeting of the American College of Psychiatrists. Tucson Arizona, February 24- March 1, 2009

Revision Principles (continued)

- Development- across the life span
- Dimensional concepts- measurement of distress, disability, and severity
- Incorporation of new knowledge- risk factors, prodromes, prevention
- Living document

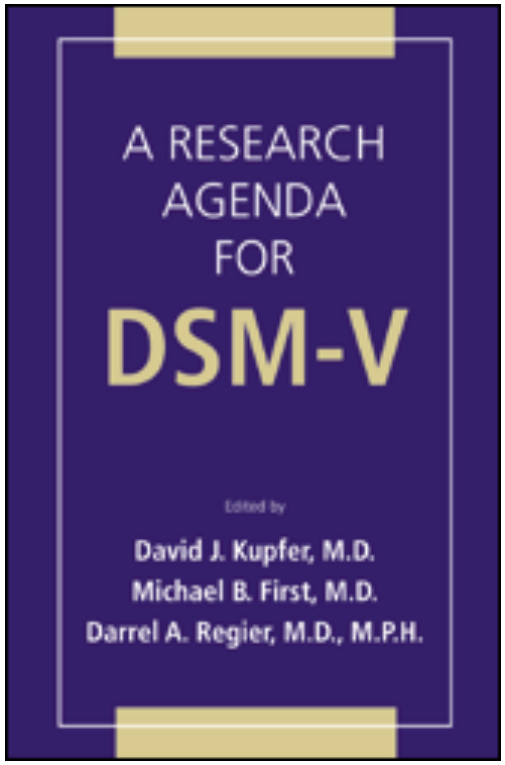
David Kupfer. Overview of DSM-V. Presented at the 2009 Annual Meeting of the American College of Psychiatrists. Tucson Arizona, February 24- March 1, 2009

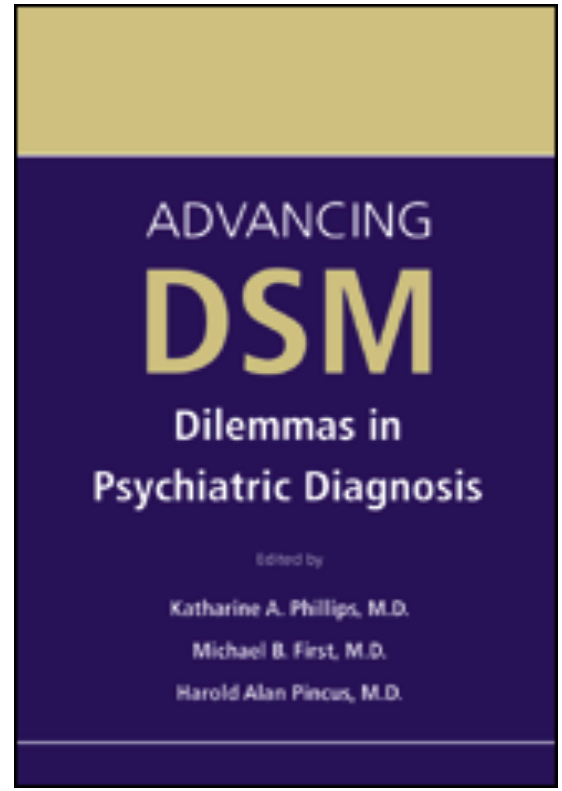
Strategies for Improving DSM

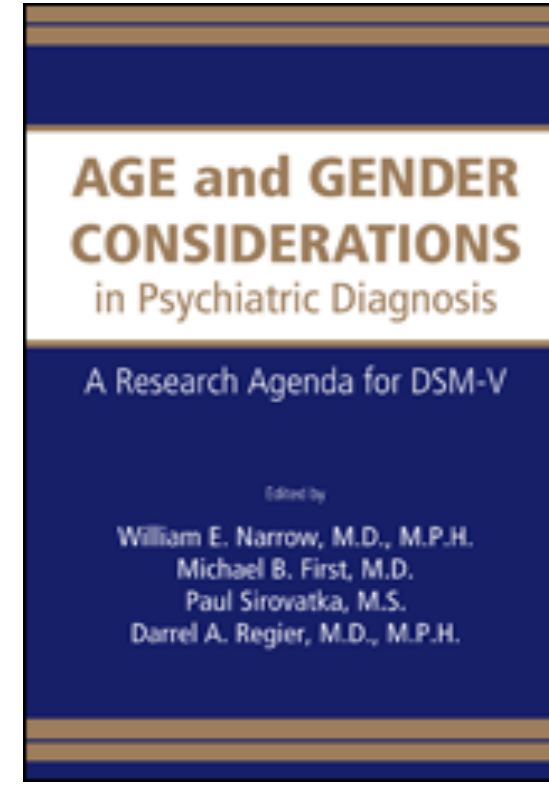
- Incorporate research into the revision and evolution of the classification
- Move beyond a process of clinical consensus and build diagnoses on a foundation of empirical findings from scientific disciplines
- Seek multidisciplinary, international scientific participation in the task of planning the DSM-5 revision

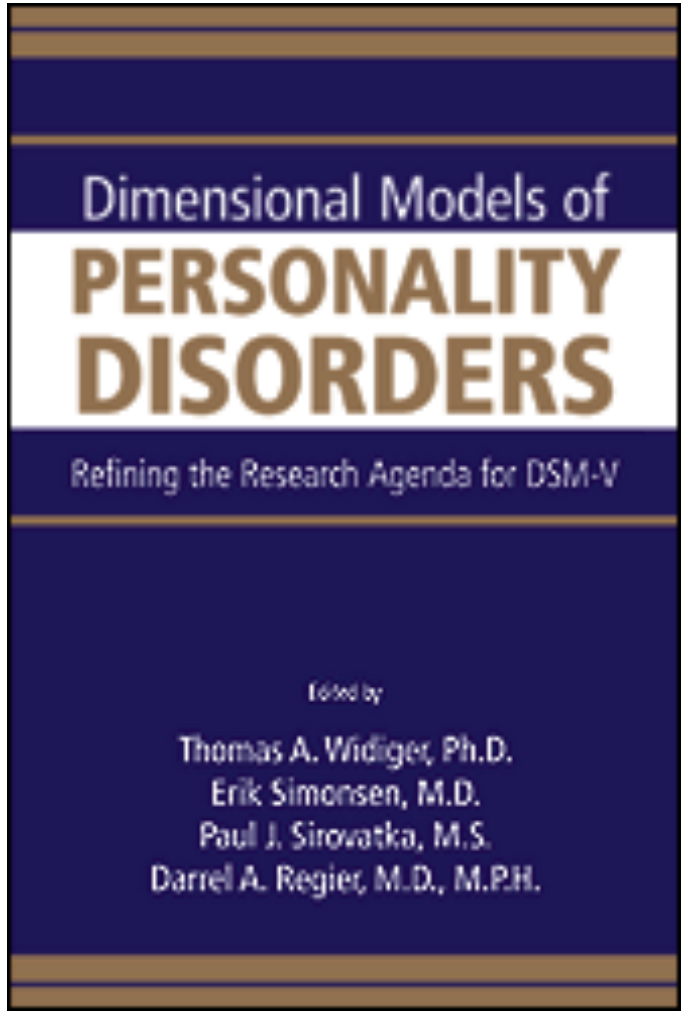
DSM-5 Conference Output

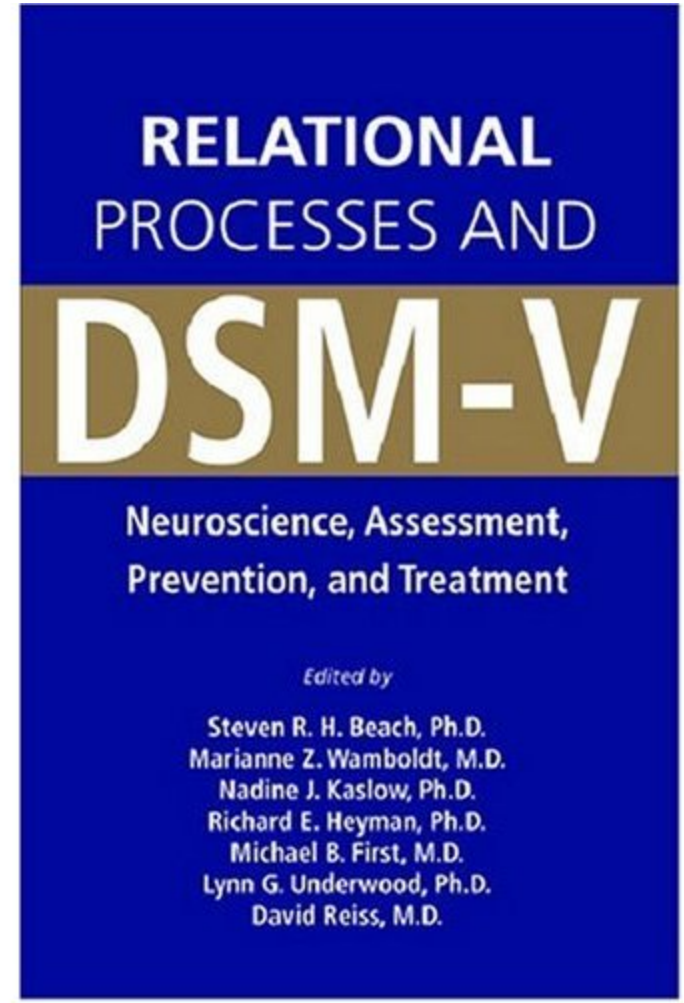
- 13 Conferences (2003-08)
- 10 monographs published
  - Dimensional Models of Personality Disorders
  - Diagnostic Issues in Substance Use Disorders
  - Diagnostic Issues in Dementia
  - Dimensional Approaches in Diagnostic Classification
  - Stress-Induced and Fear Circuitry Disorders
  - Somatic Presentations of Mental Disorders
  - Deconstructing Psychosis
  - Depression and GAD
  - Obsessive-Compulsive Behavior Spectrum Disorders
  - Public Health Aspects of Psychiatric Diagnosis
- More than 200 journal articles published


A RESEARCH
AGENDA
FOR
DSM-V
Edited by
David J. Kupfer, M.D.
Michael B. First, M.D.
Darrel A. Regier, M.D., M.P.H.


ADVANCING
DSM
Dilemmas in
Psychiatric Diagnosis
Edited by
Katharine A. Phillips, M.D.
Michael B. First, M.D.
Harold Alan Pincus, M.D.


AGE and GENDER
CONSIDERATIONS
in Psychiatric Diagnosis
A Research Agenda for DSM-V
Edited by
William E. Narrow, M.D., M.P.H.
Michael B. First, M.D.
Paul Sirovatka, M.S.
Darrel A. Regier, M.D., M.P.H.


Dimensional Models of
PERSONALITY DISORDERS
Refining the Research Agenda for DSM-V
Edited by
Thomas A. Widiger, Ph.D.
Erik Simonsen, M.D.
Paul J. Sirovatka, M.S.
Darrel A. Regier, M.D., M.P.H.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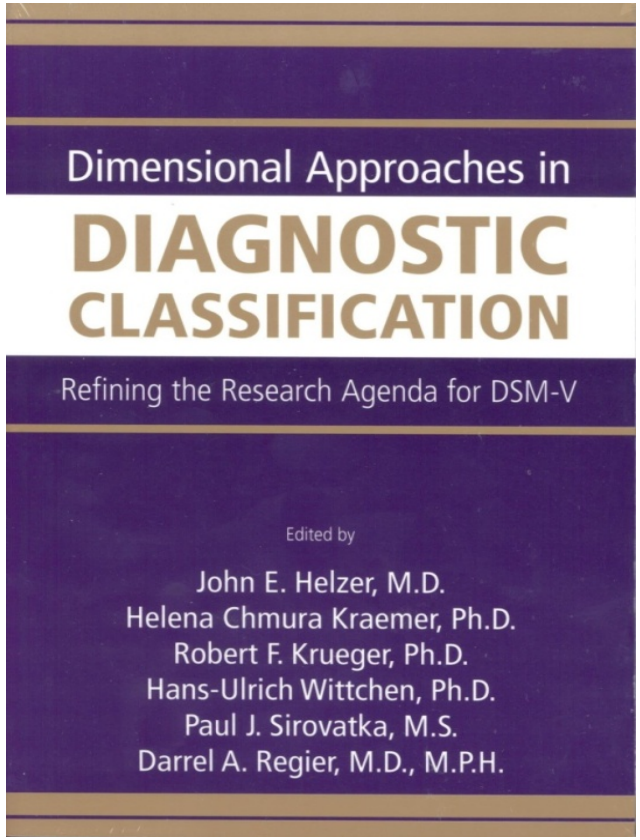
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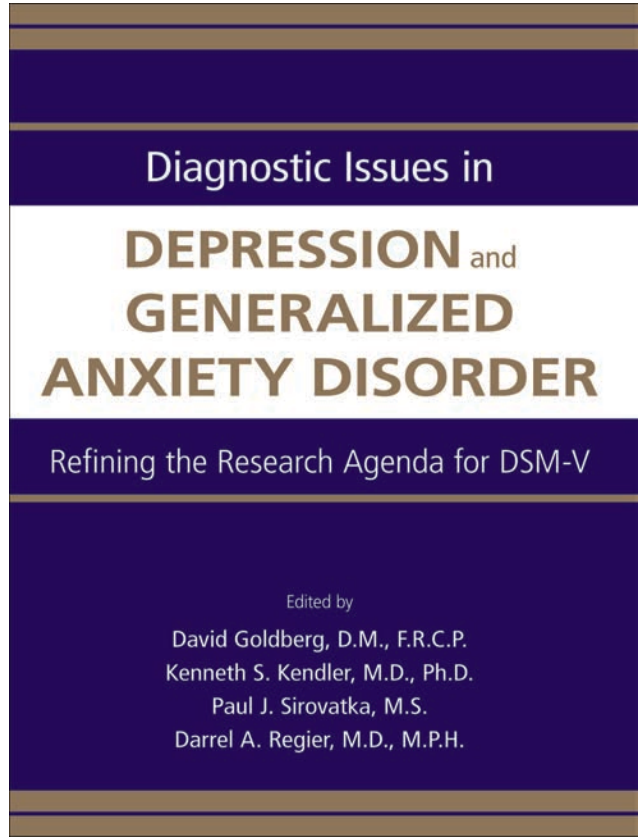
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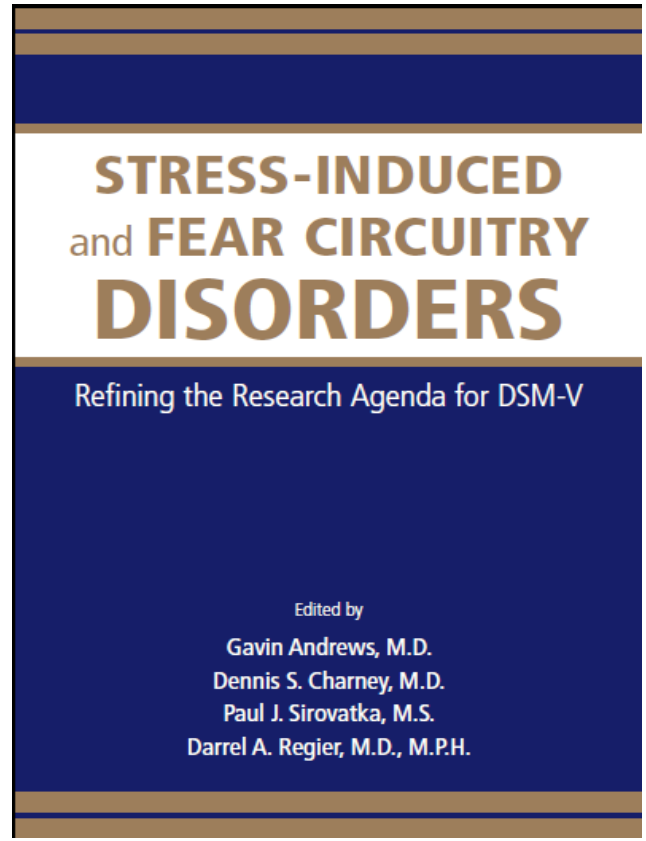
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Edited by
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"As we gradually build on our knowledge of mental disorders, we begin bridging the gap between what lies behind us (presumed etiologies based on phenomenology) and what we hope lies ahead (identifiable pathophysiologic etiologies)."

DAVID J. KUPFER, M.D.
DARREL A. REGIER, M.D., M.P.H.

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From DSM-IV-TR to DSM-5

What Specifically is Changing?

Overall Changes

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The traditional Roman numeral is gone! DSM-V to DSM-5

- Research advances will continue to require text revisions to DSM, and a TR designation, as was done with DSM-IV-TR, can only be appended once.
- Future changes prior to the manual's next complete revision will be signified as DSM-5.1, DSM-5.2, and so on.

DSM-5 Structure

Section I: DSM-5 Basics

Section II: Essential Elements: Diagnostic Criteria and Codes

Section III: Emerging Measures and Models

Appendix

Index

Section I

- Brief DSM-5 developmental history
- Guidance on use of the manual
- Definition of a mental disorder
- Cautionary forensic statement
- Brief DSM-5 classification summary

DSM-5 Chapter order

- DSM-5's 20 chapters are restructured based on disorders' apparent relatedness to one another, as reflected by:
  - similarities in disorders' underlying vulnerabilities
  - symptom characteristics
- These changes also align DSM-5 with ICD-11.

The Organization of DSM-5

- Organized in a sequence with the developmental lifespan, with disorders typically in childhood detailed first, followed by those in adolescence, adulthood and later life.
- Disorders previously addressed in a single “infancy, childhood, and adolescence” chapter are now integrated throughout the manual.

DSM-5 Organizational Structure

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma- and Stressor-Related Disorders
8. Dissociative Disorders
9. Somatic Symptom Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control, and Conduct Disorders
16. Substance Use and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilias
20. Other Disorders

Removal of Multiaxial System

DSM-5 has moved to a non-axial documentation of diagnosis, combining the former Axes I, II, and III, with separate notations for psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V).

Terminology

The phrase “general medical condition” is replaced in DSM-5 with “another medical condition” where relevant across all disorders.

Structure of Disorder Chapters

- Criteria
- Subtypes and/or specifiers
- Severity
  - Codes and recording procedures
- Explanatory text (new or expanded)
  - Diagnostic and associated features; prevalence; development and course; risk and prognosis; culture- and gender-related factors; diagnostic markers; functional consequences; differential diagnosis; comorbidity

Section III: Content

- Section III: Emerging Measures and Models
  - Assessment Measures
  - Cultural Formulation
  - Alternative DSM-5 Model for Personality Disorders
  - Conditions for Further Study

Section III: Purpose

- Section III includes a designated location for items that appear to have initial support in terms of clinical use but require further research before being officially recommended as part of the main body of the manual
  - This separation clearly conveys to readers that the content may be clinically useful and warrants review, but is not a part of an official diagnosis of a mental disorder and cannot be used as such

Section III: Content

- Section III, Conditions for Further Study
  - Attenuated Psychosis Syndrome
  - Depressive Episodes With Short Duration Hypomania
  - Persistent Complex Bereavement Disorder
  - Caffeine Use Disorder
  - Internet Gaming Disorder
  - Neurobehavioral Disorder Due to Prenatal Alcohol Exposure
  - Suicidal Behavior Disorder
  - Non-suicidal Self-Injury

Appendix: Content

- Separate from Section III, that includes:
  - Highlights of Changes From DSM-IV to DSM-5
  - Glossary of Technical Terms
  - Glossary of Cultural Concepts of Distress
  - Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
  - Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
  - Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
  - DSM-5 Advisors and Other Contributors

Changes in Specific DSM Disorder Numbers

Combination of New, Eliminated, and Combined Disorders

(net difference = -15)

Specific Mental Disorders*	DSM-IV	DSM-5
	172	157

♦*NOS (DSM-IV) and Other Specified/Unspecified (DSM-5) conditions are counted separately.

New and Eliminated Disorders in DSM-5

(net difference = +13)

New Disorders

1. **Social (Pragmatic) Communication Disorder**
2. **Disruptive Mood Dysregulation Disorder**
3. **Premenstrual Dysphoric Disorder** (DSM-IV appendix)
4. **Hoarding Disorder**
5. **Excoriation (Skin-Picking) Disorder**
6. **Disinhibited Social Engagement Disorder** (split from Reactive Attachment Disorder)
7. **Binge Eating Disorder** (DSM-IV appendix)
8. **Central Sleep Apnea** (split from Breathing-Related Sleep Disorder)
9. **Sleep-Related Hypoventilation** (split from Breathing-Related Sleep Disorder)
10. **Rapid Eye Movement Sleep Behavior Disorder** (Parasomnia NOS)
11. **Restless Legs Syndrome** (Dyssomnia NOS)
12. **Caffeine Withdrawal** (DSM-IV Appendix)
13. **Cannabis Withdrawal**
14. **Major Neurocognitive Disorder with Lewy Body Disease** (Dementia Due to Other Medical Conditions)
15. **Mild Neurocognitive Disorder** (DSM-IV Appendix)

Eliminated Disorders

1. **Sexual Aversion Disorder**
2. **Polysubstance-Related Disorder**

Combined Specific Disorders in DSM-5
(net difference = -28)

1. **Language Disorder** (Expressive Language Disorder & Mixed Receptive Expressive Language Disorder)
2. **Autism Spectrum Disorder** (Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, & Rett's disorder—PDD-NOS is in the NOS count)
3. **Specific Learning Disorder** (Reading Disorder, Math Disorder, & Disorder of Written Expression)
4. **Delusional Disorder** (Shared Psychotic Disorder & Delusional Disorder)
5. **Panic Disorder** (Panic Disorder Without Agoraphobia & Panic Disorder With Agoraphobia)
6. **Dissociative Amnesia** (Dissociative Fugue & Dissociative Amnesia)
7. **Somatic Symptom Disorder** (Somatization Disorder, Undifferentiated Somatoform Disorder, & Pain Disorder)
8. **Insomnia Disorder** (Primary Insomnia & Insomnia Related to Another Mental Disorder)
9. **Hypersomnolence Disorder** (Primary Hypersomnia & Hypersomnia Related to Another Mental Disorder)
10. **Non-Rapid Eye Movement Sleep Arousal Disorders** (Sleepwalking Disorder & Sleep Terror Disorder)

Combined Specific Disorders in DSM-5 (Continued)
(net difference = -28)

11. **Genito-Pelvic Pain/Penetration Disorder** (Vaginismus & Dyspareunia)
12. **Alcohol Use Disorder** (Alcohol Abuse and Alcohol Dependence)
13. **Cannabis Use Disorder** (Cannabis Abuse and Cannabis Dependence)
14. **Phencyclidine Use Disorder** (Phencyclidine Abuse and Phencyclidine Dependence)
15. **Other Hallucinogen Use Disorder** (Hallucinogen Abuse and Hallucinogen Dependence)
16. **Inhalant Use Disorder** (Inhalant Abuse and Inhalant Dependence)
17. **Opioid Use Disorder** (Opioid Abuse and Opioid Dependence)
18. **Sedative, Hypnotic, or Anxiolytic Use Disorder** (Sedative, Hypnotic, or Anxiolytic Abuse and Sedative, Hypnotic, or Anxiolytic Dependence)
19. **Stimulant Use Disorder** (Amphetamine Abuse; Amphetamine Dependence; Cocaine Abuse; Cocaine Dependence)
20. **Stimulant Intoxication** (Amphetamine Intoxication and Cocaine Intoxication)
21. **Stimulant Withdrawal** (Amphetamine Withdrawal and Cocaine Withdrawal)
22. **Substance/Medication-Induced Disorders** (aggregate of Mood (+1), Anxiety (+1), and Neurocognitive (-3))

Changes from NOS to Other Specified/Unspecified

(net difference = +24)

	DSM-IV	DSM-5
NOS (DSM-IV) and Other Specified/Unspecified (DSM-5)	**41**	**65**

Other Specified and Unspecified Disorders in DSM-5 replaced the Not Otherwise Specified (NOS) conditions in DSM-IV to maintain greater concordance with the official International Classification of Diseases (ICD) coding system. This statistical accounting change does not signify any new specific mental disorders.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Neurodevelopmental Disorders

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DSM-5 Neurodevelopmental Disorders

Intellectual Disabilities

- Intellectual Disability (IDD)
- Global Developmental Delay
- Unspecified Intellectual Disability

Communication Disorders

- Language Disorder
- Speech Sound Disorder (previously Phonological Disorder)
- Childhood Onset Fluency Disorder (Stuttering)
- Social (Pragmatic) Communication Disorder
- Unspecified Communication Disorder

Autism Spectrum Disorder

- Autism Spectrum Disorder

Attention-Deficit/Hyperactivity Disorder

- Attention-Deficit/Hyperactivity Disorder
- Other Specified ADHD
- Unspecified ADHD

Specific Learning Disorder

- Specific Learning Disorder

Motor Disorders

- Developmental Coordination Disorder
- Stereotypic Movement Disorder
- Tourette's Disorder
- Persistent (Chronic) Motor or Vocal Tic Disorder
- Provisional Tic Disorder
- Other Specified Tic Disorder
- Unspecified Tic Disorder

Other Neurodevelopmental Disorders

- Other Specified Neurodevelopmental Disorder
- Unspecified Neurodevelopmental Disorder

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Intellectual Disabilities

- Intellectual Disability
- Global Developmental Delay
- Unspecified Intellectual Disability

Intellectual Disability
(Intellectual Developmental Disorder)

- Mental retardation is renamed intellectual disability (intellectual developmental disorder)
  - Rationale: The term *intellectual disability* reflects the wording adopted into U.S. law in 2010 (Rosa's Law), in use in professional journals, and endorsed by certain patient advocacy groups. The term *intellectual developmental disorder* is consistent with language proposed for ICD-11.
- Greater emphasis on adaptive functioning deficits rather than IQ scores alone
  - Rationale: Standardized IQ test scores were over-emphasized as the determining factor of abilities in DSM-IV. Consideration of functioning provides a more comprehensive assessment of the individual.

Neurodevelopmental Disorders:
Intellectual Disability (IDD)

- Diagnostic criteria for ID (IDD) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning.
- Retains Severity (Mild, Moderate, Severe, Profound)
- Severity is determined by adaptive functioning rather than IQ score.

Global Developmental Delay

- Only for children under age 5 (generally before kindergarten)
- When clinical severity cannot be reliably assessed
- Requires reassessment after a period of time

Unspecified Intellectual Disability

- For children over age 5 who cannot be assessed by locally available methods
- Problems such as blindness, locomotor disability, or severe behavioral problems
- Should not be a frequently used category

Autism Spectrum Disorder (ASD)
(Neurodevelopmental Disorders)

- ASD replaces DSM-IV's autistic disorder, Asperger's disorder, childhood disintegration disorder, and pervasive developmental disorder NOS
  - Rationale: Clinicians had been applying the DSM-IV criteria for these disorders inconsistently and incorrectly; subsequently, reliability data to support their continued separation was very poor.
  - Specifiers can be used to describe variants of ASD (e.g., the former diagnosis of Asperger's can now be diagnosed as autism spectrum disorder, without intellectual impairment and without structural language impairment).

Neurodevelopmental Disorders:
Autism Spectrum Disorder

ASD is characterized by

1) Deficits in social communication and social interaction
2) Restricted repetitive behaviors (RRBs) , interests, and activities

Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

ASD Severity Specifiers

- Current severity based on social communication impairments and restricted repetitive patterns of behavior
  - Level 1: Requiring support (mild)
  - Level 2: Requiring substantial support (moderate—perhaps like Rainman)
  - Level 3: Requiring very substantial support (Severe, very little to no language
  - Support is recorded for both of the domains and may be different for each domain

Other ASD Specifiers

- With or without intellectual impairment
- With or without language impairment
- Associated with a known medical, genetic, or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder

Neurodevelopmental Disorders:
Communication Disorders

The DSM-5 communication disorders include

1. Language Disorder (combines DSM-IV expressive and mixed receptive-expressive language disorders)
2. Speech Sound Disorder (a new name for phonological disorder)
3. Childhood-Onset Fluency Disorder (a new name for stuttering)
4. Social (pragmatic) Communication Disorder

Language Disorder

- Replaces Expressive and Receptive Language disorders
- No longer separates expressive and receptive
- Retains not due to intellectual disability

Speech Sound Disorder

- Replaces DSM III Articulation Disorder and DSM IV Phonological Disorder
- Persistent difficulty with speech sound production
- Not attributable to congenital or acquired conditions

Childhood-Onset Fluency Disorder

- Very similar to DSM-IV Stuttering.
- Later-onset cases are diagnosed as adult-onset fluency disorder

Social (Pragmatic) Communication Disorder

- New diagnosis, which now may account for some DSM-IV PDD NOS cases
- Deficits for using communication for social purposes
- Impaired ability to speak differently in different settings
- Difficulty understanding what is not explicitly stated
- Onset early, but deficits may not be manifest until social communication demands exceed limited capacities

Differentiating SCD from ASD

- Presence of restricted/repetitive patterns of behavior, interests, or activities in ASD
- ASD kids may only show these in earlier years, so a comprehensive developmental history is critical
- Kids who appear quirky because of awkward communication without other “spectrum” aspects are classified SCD

Attention-Deficit/Hyperactivity Disorder

- Changed to facilitate application across the lifespan
- Age of onset changed from seven to twelve
- For age 17 through adult, five instead of six symptoms required from each section (Inattention, Hyperactivity and Impulsivity)
- Diagnosis now allowed together with ASD

Attention-Deficit/Hyperactivity Disorder

Age of onset was raised from 7 years to 12 years

- Rationale: Numerous large-scale studies indicate that, in many cases, onset is not identified until after age 7 years, when challenged by school requirements. Recall of onset is more accurate at 12 years.

The symptom threshold for adults age 17 years and older was reduced to five

- Rationale: The reduction in symptom threshold was for adults only and was made based on longitudinal studies showing that patients tend to have fewer symptoms in adulthood than in childhood. This should result in a minimal increase in the prevalence of adult ADHD.

ADHD Specifiers

- Subtypes now called specifiers: Combined, predominantly inattentive, or predominantly hyperactive-impulsive
- Partial remission, when full criteria were previously met for the past six months
- Severity: Mild, moderate, severe

Specific Learning Disorder

- Now presented as a single disorder with coded specifiers for specific deficits in reading, writing, and mathematics
  - Rationale: There was widespread concern among clinicians and researchers that clinical reality did not support DSM-IV's three independent learning disorders. This is particularly important given that most children with specific learning disorder manifest deficits in more than one area.
  - By reclassifying these as a single disorder, separate specifiers can be used to code the level of deficits present in each of the three areas for any person.

Specific Learning Disorder

- The specific learning problem is now a specifier
  - With impairment in reading
  - With impairment in written expression
  - With impairment in mathematics
  - Specify if mild, moderate or severe
- Recording is complex, and includes the impaired domain and Subskills

Subskills

- **Reading**
  - Wording reading accuracy
  - Reading rate or fluency
  - Reading comprehension
- **Written Expression**
  - Spelling accuracy
  - Grammar and punctuation accuracy
  - Clarity or organization of written expression
- **Mathematics**
  - Number sense
  - Memorization of arithmetic facts
  - Accurate or fluent calculation
  - Accurate math reasoning

Neurodevelopmental Disorders:
Motor Disorders

Motor disorders included in the DSM-5:

1) Developmental Coordination Disorder
2) Stereotypic Movement Disorder

Tic Disorders

3) Tourette's Disorder
4) Persistent (chronic) Motor or Vocal Tic Disorder
5) Provisional Tic Disorder
6) Other Specified Tic Disorder
7) Unspecified Tic Disorder

Developmental Coordination Disorder

- Some wording changes with more examples but no major changes

Stereotypic Movement Disorder

- Some wording changes, no major changes

Tic Disorders

- These disorders are essentially unchanged
- Transient Tic Disorder is now Provisional Tic Disorder
- In Provisional Tic Disorder, changed from at least 4 weeks duration up to one year, to present for less than one year
- Specifiers are only required for Persistent Tic Disorder, and are Motor tics only or Vocal tics only if they apply

Key Points
Neurodevelopmental Disorders

- Autism spectrum disorder (ASD) replaces the four *DSM-IV* autism diagnoses and includes expanded specifiers and ratings of severity.
- Social communication disorder describes children who exhibit deficits in language and communication but do not have restrictive/repetitive behaviors necessary for ASD.
  - These children would typically receive a *DSM-IV* diagnosis of pervasive developmental disorder NOS.

Key Points (continued)
Neurodevelopmental Disorders

- Specific learning disorder consolidates four *DSM-IV* learning disorders, but includes specifiers related to deficits in reading, written expression, and mathematics.
- Intellectual disability, replacing the *DSM-IV* category of "mental retardation," requires both adaptive-functioning assessments and IQ scores for diagnosis.

Key Points (continued)
Neurodevelopmental Disorders

- Attention deficit/hyperactivity disorder has been added to this diagnostic category and is largely unchanged from DSM-IV except:
  - Age of onset increased from 7 to 12.
  - Subtypes of inattentive, hyperactive, and mixed are now presentation specifiers.
  - Threshold for diagnosis in adults is adjusted to five symptoms in either domain.

Key Points (continued)
Neurodevelopmental Disorders

- Three communication disorders—language disorder, childhood onset fluency disorder (stuttering), and speech sound disorder—replace DSM-IV diagnoses of expressive language disorder, stuttering, and phonological disorder, respectively.
- Criteria for motor disorders are largely unchanged.
  - *DSM-5* criteria for Tourette's syndrome and chronic motor or vocal tic disorder state that tics may "wax and wane in frequency but have persisted for more than a year." *DSM-IV* criteria had stated that "tics occur many times a day nearly every day."

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria

Schizophrenia Spectrum and Other Psychotic Disorders

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Schizophrenia Spectrum and Other Psychotic Disorders

1. Schizotypal Personality Disorder
2. Delusional Disorder
3. Brief Psychotic Disorder
4. Schizophreniform Disorder
5. Schizophrenia
6. Schizoaffective Disorder
7. Substance/Medication-Induced Psychotic Disorder
8. Psychotic Disorder Due to Another Medical Condition
9. Catatonia Associated with Another Mental Disorder (Catatonia Specifier)
10. Catatonic Disorder Due to Another Medical Condition
11. Unspecified Catatonia
12. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
13. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

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Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia- Two changes to DSM-IV Criterion A:

1. Elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing).
   - In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was removed and, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia.
2. Addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech.
   - At least one of these core "positive symptoms" is necessary for a reliable diagnosis of schizophrenia.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia subtypes

The DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizoaffective Disorder

- The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder's total duration after Criterion A has been met.
- This change was made on both conceptual and psychometric grounds. It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis.

Schizophrenia Spectrum and Other Psychotic Disorders

Delusional Disorder

- Criterion A for delusional disorder no longer has the requirement that the delusions must be non-bizarre.
- The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted:
  - A new exclusion criterion- the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs.

Schizophrenia Spectrum and Other Psychotic Disorders

Delusional Disorder (continued)

- DSM-5 no longer separates delusional disorder from shared delusional disorder.
  - If criteria are met for delusional disorder then that diagnosis is made.
  - If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.

Schizophrenia Spectrum and Other Psychotic Disorders

Catatonia

Now exists as a specifier for neurodevelopmental, psychotic, mood and other mental disorders; as well as for other medical disorders (catatonia due to another medical condition)

- Rationale: As represented in DSM-IV, catatonia was under-recognized, particularly in psychiatric disorders other than schizophrenia and psychotic mood disorders and in other medical disorders. It was also apparent that inclusion of catatonia as a specific condition that can apply more broadly across the manual may help address gaps in the treatment of catatonia.

Schizophrenia Spectrum and Other Psychotic Disorders

Catatonia (continued)

- The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition.
  - All contexts require three catatonic symptoms (from a total of 12 characteristic symptoms).
    - In DSM-IV, two out of five symptom clusters were required if the context was a psychotic or mood disorder, whereas only one symptom cluster was needed if the context was a general medical condition.

Schizophrenia Spectrum and Other Psychotic Disorders: Area for Further Study

- Attenuated psychosis syndrome is included in Section III of the new manual; conditions listed there require further research before their consideration as formal disorders.
  - This potential category would identify a person who does not have a full-blown psychotic disorder but exhibits minor versions of relevant symptoms.
- Identifying individuals with an increased risk for developing a psychotic disorder is significant for effective early intervention, but more study is needed to ensure that attenuated psychosis syndrome can be reliably diagnosed.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Bipolar and Related Disorders

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Bipolar and Related Disorders

1. Bipolar I Disorder
2. Bipolar II Disorder
3. Cyclothymic Disorder
4. Substance/Medication-Induced Bipolar and Related Disorder
5. Bipolar and Related Disorder Due to Another Medical Condition
6. Other Specified Bipolar and Related Disorder
7. Unspecified Bipolar and Related Disorder

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Bipolar and Related Disorders

Mania and Hypomania

- Inclusion of increased energy/activity as a Criterion A symptom of mania and hypomania
  - Rationale: This will make explicit the requirement of increased energy/activity in order to diagnose bipolar I or II disorder (which is not required under DSM-IV) and will improve the specificity of the diagnosis.

Bipolar and Related Disorders

- "Mixed episode" is replaced with a "with mixed features" specifier for manic, hypomanic, and major depressive episodes
  - Rationale: DSM-IV criteria excluded from diagnosis the sizeable population of individuals with subthreshold mixed states who did not meet full criteria for major depression *and* mania, and thus were less likely to receive treatment.

Bipolar and Related Disorders

"With anxious distress" also added as a specifier for bipolar (and depressive) disorders

- Rationale: The co-occurrence of anxiety with depression is one of the most commonly seen comorbidities in clinical populations. Addition of this specifier will allow clinicians to indicate the presence of anxiety symptoms that are not reflected in the core criteria for depression and mania but nonetheless may be meaningful for treatment planning.

Bipolar and Related Disorders

Other Specified Bipolar and Related Disorder

DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, for example:

- Individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days).
- Too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration is sufficient at 4 or more days.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Depressive Disorders

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Depressive Disorders

1. Disruptive Mood Dysregulation Disorder
2. Major Depressive Disorder, Single and Recurrent Episodes
3. Persistent Depressive Disorder (Dysthymia)
4. Premenstrual Dysphoric Disorder
5. Substance/Medication-Induced Depressive Disorder
6. Depressive Disorder Due to Another Medical Condition
7. Other Specified Depressive Disorder
8. Unspecified Depressive Disorder

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Depressive Disorders

New in DSM-5

- **Disruptive mood dysregulation disorder**- made over 6/under 18 - verbal or behavioral angry outbursts, out of proportion, 3 or more times weekly with general irritable mood most of the time for at least 12 months, with no three month period free of episodes.
- **Premenstrual dysphoric disorder** has been moved from DSM-IV Appendix B to the main body of DSM-5.
- **Persistent Depressive Disorder-** combines dysthymic disorder and Chronic MDD

Disruptive Mood Dysregulation Disorder (DMDD)

- This addresses the disturbing increase in pediatric bipolar diagnoses over the past two decades, which is due in large part to the incorrect characterization of non-episodic irritability as a hallmark symptom of mania.
- DMDD provides a diagnosis for children with extreme behavioral dyscontrol but persistent, rather than episodic, irritability and reduces the likelihood of such children being inappropriately prescribed antipsychotic medication.
- These criteria do not allow a dual diagnosis with oppositional-defiant disorder (ODD) or intermittent explosive disorder (IED), but it can be diagnosed with conduct disorder (CD). Children who meet criteria for DMDD and ODD would be diagnosed with DMDD only.

Premenstrual Dysphoric Disorder

- Criteria A: in the majority of menstrual cycles at least 5 of symptoms must be present in the final week before menses, improve at cessation of menses, and be diminished or absent the week after menses.
- Criteria B: One or more: 1.Marked affective liability 2. Marked irritability 3. Marked depression, hopelessness or self depreciation 4. Marked anxiety, tension, feeling keyed up or on edge.
- Criteria C: One or more to reach a total of five symptoms: 1.Decreased interest 2. Lethargy 3. Decreased concentration 4. Marked change in appetite 5.Sleep disturbance 6. Feeling overwhelmed/ out of control 7. Physical symptoms – tender or swelling breasts, muscle pain, bloating, weight gain.
- Symptoms must have occurred most of periods past year, be significantly distressing, not an exacerbation of a present disorder, be measured by ratings of at least 2 prior symptomatic cycles.

Depressive Disorders

Persistent Depressive Disorder

- DSM-5 conceptualizes chronic forms of depression in a somewhat modified way.
- This new disorder will include two of the DSM-IV disorders:
    - Dysthymic disorder
    - Chronic major depressive disorder
- An inability to find scientifically meaningful differences between these two conditions led to their combination with specifiers included to identify different pathways to the diagnosis and to provide continuity with DSM-IV.

Depressive Disorders

Major Depressive Disorder

- Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life.
- The coexistence within a major depressive episode of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier “with mixed features.”
  - The presence of mixed features in an episode of major depressive disorder increases the likelihood that the illness exists in a bipolar spectrum; however, if the individual concerned has never met criteria for a manic or hypomanic episode, the diagnosis of major depressive disorder is retained.

Bereavement Exclusion

Eliminated from major depressive episode (MDE)

- Rationale: In some individuals, major loss – including but not limited to loss of a loved one – can lead to MDE or exacerbate pre-existing depression. Individuals experiencing both conditions can benefit from treatment but are excluded from diagnosis under DSM-IV. Further, the 2-month timeframe required by DSM-IV suggests an arbitrary time course to bereavement that is inaccurate. Lifting the exclusion alleviates both of these problems.

Depressive Disorders

Bereavement Exclusion (continued)

Although most people experiencing the loss of a loved one experience bereavement without developing a major depressive episode, evidence does not support the separation of loss of a loved one from other stressors in terms of its likelihood of precipitating a major depressive episode or the relative likelihood that the symptoms will remit spontaneously.

Depressive Disorders

Specifiers for Depressive Disorders

- Guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to make a determination of the prominence of suicide prevention in treatment planning for a given individual.
- A new specifier to indicate the presence of **mixed symptoms** has been added across both the bipolar and the depressive disorders, allowing for the possibility of manic features in individuals with a diagnosis of unipolar depression.
- The "**with anxious distress**" specifier gives the clinician an opportunity to rate the severity of anxious distress in all individuals with bipolar or depressive disorders.

Depressive Disorders

Specifiers for Depressive Disorders

- Change Post-Partum Depression to a Peri-Partum Depression specifier to reflect that an MDE can occur during pregnancy as well as after parturition.
- MDE still must occur within 4 weeks of parturition to qualify for Peri-Partum Depression specifier.

Specified vs. Unspecified Mood Diagnoses

Examples of **Other Specified Depressive Disorder**

1. Recurrent Brief Depression: Depressed mood plus four other symptoms lasting 2-13 days occurring monthly for at least 12 months.
2. Short Duration Depression 5/9 criteria symptoms for 4-13 days.
3. Depressive Episode with insufficient symptoms – Depressive mood plus one other symptom with clinically significant distress or impairment.

Unspecified Depressive Disorder – Insufficient information but clinician suspects depressive disorder with clinically significant distress or impairment. e.g. emergency room diagnosis

Agenda

9:00 am	Introduction to the Workshop
9:15 am	History of Diagnostic Classification and Development of the DSM
10:00 am	Overall Changes: From DSM-IV-TR to DSM-5
10:15 am	BREAK
10:30 am	Specific Changes: Neurodevelopmental Disorders
11:00 am	Specific Changes: Schizophrenia Spectrum and Other Psychotic Disorders
11:30 am	Specific Changes: Bipolar and Depressive Disorders
12:00 pm	**LUNCH**
1:00 pm	Specific Changes: Anxiety, Obsessive-Compulsive, Trauma-Related, and Dissociative Disorder
1:45 pm	Specific Changes: Somatic Symptom, Eating, Sleep, and other Disorders
2:15 pm	BREAK
2:30 pm	Specific Changes: Impulse Control, Substance Use, Neurocognitive, and Personality Disorders
3:15 pm	Codes Issues and Insurance Implications
3:45 pm	Q & A
4:00 pm	ADJOURNMENT

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Break for Lunch

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Anxiety Disorders

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Anxiety Disorders

1. Separation Anxiety Disorder
2. Selective Mutism
3. Specific Phobia
4. Social Anxiety Disorder (Social Phobia)
5. Panic Disorder
6. Panic Attack
7. Agoraphobia
8. Generalized Anxiety Disorder
9. Substance/Medication-Induced Anxiety Disorder
10. Anxiety Disorder Due to Another Medical Condition
11. Other Specified Anxiety Disorder
12. Unspecified Anxiety Disorder

Anxiety Disorders

Separation of DSM-IV Anxiety Disorders chapter into four distinct chapters:

- Rationale: Data from neuroscience, neuroimaging, and genetic studies suggest differences in the heritability, risk, course, and treatment response among fear-based anxiety disorders (e.g., phobias); disorders of obsessions or compulsions (e.g., OCD); trauma-related anxiety disorders (e.g., PTSD); and dissociative disorders. Thus, four anxiety-related classifications are present in DSM-5, instead of two chapters in DSM-IV.

DSM-IV Anxiety Disorders in DSM-5

- **Anxiety Disorders**
  - Panic, Specific Phobia, Social Phobia, GAD etc.
- **OC, Stereotypic, and Related Disorders**
  - OCD, Body Dysmorphic, Hoarding, Hair Pulling, Skin Picking, etc.
- **Trauma- and Stressor-Related Disorders**
  - PTSD, ASD, ADs, RAD, DSES.
- **Dissociative Disorders**
  - DID, Depersonalization/Derealization, Dissociative Amnesia, etc.

Panic Attacks Specifier

Now a specifier for any mental disorder

- Rationale: Panic attacks can predict the onset severity and course of mental disorders, including anxiety disorders, bipolar disorder, depression, psychosis, substance use disorders, and personality disorders.

Anxiety Disorders

Panic Attack

- The essential features of panic attacks remain unchanged.
- The complicated DSM-IV terminology for describing different types of panic attacks (i.e., situationally bound/ cued, situationally predisposed, and unexpected/uncued) is replaced with the terms unexpected and expected panic attacks.
- Panic attack can be listed as a specifier that is applicable to all DSM-5 disorders.

Anxiety Disorders

Panic Disorder and Agoraphobia

- Panic disorder and agoraphobia are unlinked in DSM-5:
  - The former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria.
- The co-occurrence of panic disorder and agoraphobia is now coded with two diagnoses.

Anxiety Disorders

Changes in criteria for
Agoraphobia, Specific Phobia, and Social Anxiety Disorder

- Deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable.
  - Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after taking cultural contextual factors into account.
- 6-month duration, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages. This change is intended to minimize over-diagnosis of transient fears.

Anxiety Disorders

Specific Phobia

- The core features remain the same
- There is no longer a requirement that individuals over age 18 years must recognize that their fear and anxiety are excessive or unreasonable
- The duration requirement ("typically lasting for 6 months or more") now applies to all ages.
- Different types of specific phobia have essentially remained unchanged.

Anxiety Disorders

Social Anxiety Disorder (Social Phobia)

- Deletion of the requirement that individuals over age 18 years must recognize that their fear or anxiety is excessive or unreasonable,
- Duration criterion of "typically lasting for 6 months or more" is now required for all ages.
- "Generalized" specifier has been deleted and replaced with a "performance only" specifier.
  - The DSM-IV generalized specifier was problematic in that "fears include most social situations" was difficult to operationalize. Individuals who fear only performance situations (i.e., speaking or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.

Anxiety Disorders

Separation Anxiety Disorder (Classified in DSM-IV in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.")

- The core features remain mostly unchanged, although the wording of the criteria has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood.
  - For example, attachment figures may include the children of adults with separation anxiety disorder, and avoidance behaviors may occur in the workplace as well as at school.
- The diagnostic criteria no longer specify that age at onset must be before 18 years.
- A duration criterion—"typically lasting for 6 months or more"—has been added for adults to minimize overdiagnosis of transient fears.

Anxiety Disorders

Selective Mutism

- Classified in DSM-IV in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence," is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious.
- The diagnostic criteria are largely unchanged from DSM-IV.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Obsessive-Compulsive and Related Disorders

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Obsessive-Compulsive and Related Disorders

1. Obsessive-Compulsive Disorder
2. Body Dysmorphic Disorder
3. Hoarding Disorder
4. Trichotillomania (Hair-Pulling Disorder)
5. Excoriation (Skin-Picking) Disorder
6. Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
7. Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
8. Other Specified Obsessive-Compulsive and Related Disorder
9. Unspecified Obsessive-Compulsive and Related Disorder

Obsessive-Compulsive and Related Disorders

- The chapter on obsessive-compulsive and related disorders, which is new in DSM-5, reflects the increasing evidence that these disorders are related.
- New disorders include:
  - **Hoarding disorder**
  - **Excoriation (skin-picking) disorder**
  - **Substance-/medication-induced OC and related disorder**
  - **OC and related disorder due to another medical condition**
- The DSM-IV diagnosis of trichotillomania has been moved from a DSM-IV classification of impulse-control disorders NOS to obsessive-compulsive and related disorders in DSM-5.

Obsessive-Compulsive and Related Disorders

Specifiers for Obsessive-Compulsive and Related Disorders

- The "with poor insight" specifier has been refined to:
  - With good or fair insight
  - With poor insight
  - With absent insight/delusional
- Analogous "insight" specifiers have been included for body dysmorphic disorder and hoarding disorder.
- The "**tic-related**" specifier
  - Reflects a growing literature on the diagnostic validity and clinical utility of identifying individuals with a current or past comorbid tic disorder.

Obsessive-Compulsive and Related Disorders

Body Dysmorphic Disorder

- A diagnostic criterion describing repetitive behaviors or mental acts in response to preoccupations with perceived defects or flaws in physical appearance has been added.
- A "with muscle dysmorphia" specifier has been added.
- The delusional variant of body dysmorphic disorder is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder:
  - In DSM-5 this presentation is designated only as body dysmorphic disorder with the absent insight/delusional beliefs specifier.

Obsessive-Compulsive and Related Disorders

Hoarding Disorder is a new diagnosis in DSM-5

- DSM-IV lists hoarding as one of the possible symptoms of OCPD and notes that extreme hoarding may occur in OCD.
- However, available data do not indicate that hoarding is a variant of OCD or another mental disorder.
- Instead, there is evidence for the diagnostic validity and clinical utility of a separate diagnosis of hoarding disorder, which reflects persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them.
  - Hoarding disorder may have unique neurobiological correlates, is associated with significant impairment, and may respond to clinical intervention.

Obsessive-Compulsive and Related Disorders

Trichotillomania (Hair-Pulling Disorder) was included in DSM-IV, although "hair-pulling disorder" has been added parenthetically to the disorder's name in DSM-5.

Excoriation (Skin-Picking) Disorder: Newly added to DSM-5, with strong evidence for its diagnostic validity and clinical utility.

Obsessive-Compulsive and Related Disorders

Substance/Medication-Induced OC and Related Disorder and OC and Related Disorder Due to Another Medical Condition

- DSM-IV included a specifier "with obsessive-compulsive symptoms" in the diagnoses of anxiety disorders due to a general medical condition and substance-induced anxiety disorders.
- Given that obsessive-compulsive and related disorders are now a distinct category, DSM-5 includes these new.
- This change is consistent with the intent of DSM-IV, and it reflects the recognition that substances, medications, and medical conditions can present with symptoms similar to primary obsessive-compulsive and related disorders.

Obsessive-Compulsive and Related Disorders

Other Specified Obsessive-Compulsive and Related Disorders

- Can include conditions such as
  - Body-focused repetitive behavior disorder- characterized by recurrent behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors.
  - Obsessional jealousy is characterized by nondelusional preoccupation with a partner's perceived infidelity.

Other Unspecified Obsessive-Compulsive and Related Disorders

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Trauma and Stressor-Related Disorders

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Trauma- and Stressor-Related Disorders

1. Reactive Attachment Disorder
2. Disinhibited Social Engagement Disorder
3. Posttraumatic Stress Disorder
4. Acute Stress Disorder
5. Adjustment Disorders
6. Other Specified Trauma- and Stressor-Related Disorder
7. Unspecified Trauma- and Stressor-Related Disorder

Posttraumatic Stress Disorder
(Trauma- and Stress-Related Disorders)

The stressor criterion (Criterion A) is more explicit (e.g., elimination of "non-violent death of a loved one" as a trigger) and subjective reaction (Criterion A2) is eliminated

- Rationales: Direct and indirect exposure to trauma are still reflected in the criteria, but a review of the literature indicated more restrictive wording was needed. Criterion A2 is not well-supported by the data and rarely endorsed by military and other professionals who otherwise would meet full criteria for PTSD.

Posttraumatic Stress Disorder (cont'd)

Expansion to four symptom clusters (intrusion symptoms; avoidance symptoms; negative alterations in mood and cognition; alterations in arousal and reactivity), with the avoidance/numbing cluster divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood

- Rationale: Confirmatory factor analyses suggest PTSD is best conceptualized by four factors rather than three. Further, active avoidance and emotional numbing have been shown to be distinct; thus they have been separated here (with numbing expanded to include negative mood and cognitive symptoms).

Posttraumatic Stress Disorder (cont'd)

Separate criteria are now available for PTSD occurring in preschool-age children (i.e., 6 years and younger)

- Rationale: DSM-IV criteria for PTSD were not developmentally sensitive to very young children. For instance, young children are limited in their capacity to describe cognitions and internal experiences. Numerous studies indicate that children exposed to trauma can exhibit significant anxiety and other forms of distress that warrant treatment but, due to the inadequacy of the adult criteria, do not meet threshold for PTSD in DSM-IV.

Child PTSD Symptoms (A)

- The adult criteria are used in children older than age 6
- Exposure is to actual or threatened death, serious injury, or sexual violence--(Witnessing does not include by electronic media)
- Can include learning that trauma occurred to a caregiver

Child PTSD Symptoms (B)

- Recurrent intrusive memories, not necessarily appearing distressing, and may be expressed as play reenactment, and/or
- Related distressing dreams, and/or
- Flashbacks, and/or
- Distress at exposure to internal or external cues, and or
- Marked physiological reactions to reminders

Child PTSD Symptoms (C)

- Persistent avoidance of stimuli, and/or
- Negative alterations in cognitions which includes negative emotional states, diminished interest in activities, withdrawn behavior, few positive emotions expressed

Child PTSD Symptoms (D)

- Alterations in arousal, with 2 of the following:
  - Irritable behavior and angry outbursts
  - Hypervigilance
  - Increased startle
  - Problems concentrating
  - Sleep problems

Trauma and Stressor Related Disorders

Reactive Attachment Disorder- DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited.

- In DSM-5, these subtypes are defined as distinct disorders:
  - **Reactive Attachment Disorder**
  - **Disinhibited Social Engagement Disorder**.

RAD and DSED

DSM-IV's reactive attachment disorder (RAD) subtypes are now two distinct disorders: RAD and disinhibited social engagement disorder (DSED)

- Rationale: These appear to be two distinct conditions that are characterized by different attachment behaviors.
  - DSED is more similar to ADHD and disruptive behavior disorders and reflects poorly formed or absent attachments to others.
  - RAD is more similar to depression and other internalizing disorders but occurs in children with both insecure and more secure attachments.

Trauma and Stressor Related Disorders

Acute Stress Disorder

- The stressor criterion (Criterion A) now requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly.
- DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (e.g., “the person’s response involved intense fear, helplessness, or horror”) has been eliminated.
- Individuals may meet diagnostic criteria in DSM-5 for acute stress disorder if they exhibit any 9 of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance, and arousal.

Trauma and Stressor Related Disorders

Adjustment Disorders

- Reconceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or nontraumatic) event:
  - Rather than as a residual category for individuals who exhibit clinically significant distress without meeting criteria for a more discrete disorder (as in DSM-IV).
- DSM-IV subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct have been retained, unchanged.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Dissociative Disorders

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Dissociative Disorders

1. Dissociative Identity Disorder
2. Dissociative Amnesia
3. Depersonalization/Derealization Disorder
4. Other Specified Dissociative Disorder
5. Unspecified Dissociative Disorder

Dissociative Disorders

1. Derealization is included in the name and symptom structure of what previously was called depersonalization disorder and is now called *depersonalization/derealization disorder*
2. Dissociative fugue is now a specifier of dissociative amnesia rather than a separate diagnosis

Dissociative Disorders

Changes in the Criteria for Dissociative Identity Disorder

- Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder
- Criterion A now specifically states that transitions in identity may be observable by others or self-reported
- Criterion B- individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences.
- Other text modifications clarify the nature and course of identity disruptions.

Dissociative Identity Disorder
(Dissociative Disorders)

Additional text to support Criterion D (exclusion based on cultural or religious practices)

- Rationale: This acknowledges that possession states are commonly recognized in cultures around the world and do not necessarily indicate presence of DID or any other mental disorder. In contrast, possession-form DID is recurrent and unwanted, leads to distress or impairment, and is not part of a broadly accepted cultural or religious practice.

Dissociative Amnesia

Now includes a dissociative fugue specifier, which was previously an independent disorder

- Rationale: This revision was implemented due to a lack of clinical and epidemiological data supporting dissociative fugue as an independent disorder and due to the low validity of DSM-IV dissociative fugue criteria.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Somatic Symptom and Related Disorders

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Somatic Symptom and Related Disorders

1. Somatic Symptom Disorder
2. Illness Anxiety Disorder
3. Conversion Disorder (Functional Neurological Symptom Disorder)
4. Psychological Factors Affecting Other Medical Conditions
5. Factitious Disorder
6. Other Specified Somatic Symptom and Related Disorder
7. Unspecified Somatic Symptom and Related Disorder

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Somatoform Disorders: Problems with DSM-IV

- Overlapping disorders (lack of clarity about their boundaries)
- Criteria are too sensitive and too specific
- Pejorative
- Mind-body dualism
- Over-emphasis on medically unexplained symptoms
- Disorders can occur with or without medical diagnoses
- Confusing to primary care doctors
- Physicians don't use

Somatic Symptom and Related Disorders

- Somatoform disorders are now referred to as somatic symptom and related disorders.
- The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap.
- Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

Somatic Symptom and Related Disorders

Medically Unexplained Symptoms

- DSM-IV criteria overemphasized the importance of an absence of a medical explanation for the somatic symptoms.
  - The reliability of medically unexplained symptoms is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind -body dualism.
- The DSM-5 classification defines disorders on the basis of positive symptoms (i.e., distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms).
- Medically unexplained symptoms do remain a key feature in conversion disorder and pseudocyesis because it is possible to demonstrate definitively in such disorders that the symptoms are not consistent with medical pathophysiology.

Somatic Symptom and Related Disorders

The central focus of medically unexplained symptoms has been de-emphasized throughout the chapter, and instead emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms

- Rationale: The reliability of medically unexplained symptoms is low. Further, presence of medically explained symptoms *does not* rule out the possibility of a somatic symptom or related disorder being present.

Somatic Symptom Disorder (SSD)

Replaces somatoform disorder, undifferentiated somatoform disorder, hypochondriasis, and the pain disorders

- Rationale: DSM-IV's somatoform disorders have been shown to be rarely used in most clinics and across numerous countries, due in part to criteria and terminology that are confusing, unreliable, and not valid.
- SSD is projected to cover the majority of patients previously diagnosed with its subsumed DSM-IV disorders, with illness anxiety disorder (new to DSM-5) likely covering the remainder.

Somatic Symptom Disorder

- DSM-5 better recognizes the complexity of the interface between psychiatry and medicine.
- Individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors *may or may not* have a diagnosed medical condition. The relationship between somatic symptoms and psychopathology exists along a spectrum.

Somatic Symptom Disorder (cont'd)

- Individuals previously diagnosed with somatization disorder will usually meet DSM-5 criteria for somatic symptom disorder, but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.
- Because in DSM-IV the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

Somatic Symptom and Related Disorders

Hypochondriasis and Illness Anxiety Disorder

- Hypochondriasis has been eliminated as a disorder, in part because the name was perceived as pejorative and not conducive to an effective therapeutic relationship.
- Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder.
- In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

Somatic Symptom and Related Disorders

Pain Disorder

- In DSM-IV, the pain disorder diagnoses assume that some pains are associated solely with psychological factors, some with medical diseases or injuries, and some with both.
- There is a lack of evidence that such distinctions can be made with reliability and validity, and a large body of research has demonstrated that psychological factors influence all forms of pain.
- In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

Somatic Symptom and Related Disorders

Psychological Factors Affecting Other Medical Conditions

- A new mental disorder in DSM-5, having formerly been included in the DSM-IV chapter "Other Conditions That May Be a Focus of Clinical Attention."

Factitious Disorder

- Now placed among the somatic symptom and related disorders because somatic symptoms are predominant feature.

Somatic Symptom and Related Disorders

Conversion Disorder
(Functional Neurological Symptom Disorder)

- Criteria are modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Feeding and Eating Disorders

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Feeding and Eating Disorders

1. Pica
2. Rumination Disorder
3. Avoidant/Restrictive Food Intake Disorder
4. Anorexia Nervosa
5. Bulimia Nervosa
6. Binge Eating Disorder
7. Other Specified Feeding and Eating Disorder
8. Unspecified Feeding and Eating Disorder

Elimination Disorders

1. Enuresis
2. Encopresis
3. Other Specified Elimination Disorder
4. Unspecified Elimination Disorder

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Feeding and Eating Disorders

- This chapter in DSM-5 includes several disorders included in DSM-IV as feeding and eating disorders of infancy or early childhood in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.”

Feeding and Eating Disorders

Pica and Rumination Disorder

- The DSM-IV criteria have been revised for clarity
- The diagnoses can be made for individuals of any age.

Avoidant/Restrictive Food Intake Disorder

- DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded.

Avoidant/Restrictive Food Intake Disorder (ARFID)

Feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder

- Rationale: The new name will facilitate more accurate diagnosis in children presenting to pediatric clinics with significantly restricted eating patterns or nutritional problems, thus also likely reducing the use of the unspecified eating or feeding disorder diagnosis in DSM-5 (formerly EDNOS in DSM-IV).

Feeding and Eating Disorders

Anorexia Nervosa

- The core diagnostic criteria are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated.
- The wording of the criterion has been changed for clarity, and guidance regarding how to judge whether an individual is at or below a significantly low weight is now provided in the text.
- Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.

Anorexia Nervosa (AN)

Diagnosis no longer requires amenorrhea

- Rationale: This requirement was already excluded for males, premenarcheal and postmenopausal females, and women using birth control pills.
- Data indicate females who menstruate but otherwise meet criteria for AN are clinically similar to non-menstruating females with AN.

Feeding and Eating Disorders

Bulimia Nervosa

- The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly.

Binge Eating Disorder (BED)
(Feeding and Eating Disorders)

Elevated to the main body of the manual from DSM-IV's Appendix

- Rationale: BED is highly recognized in the clinical literature as a valid and clinically useful diagnosis. Further, a significant proportion of cases of DSM-IV's eating disorder NOS would meet criteria for BED; therefore, this should reduce use of the unspecified eating and feeding disorder designation in DSM-5.

Binge Eating Disorder (BED)

- Previously included in Appendix B of DSM-IV.
- The only significant difference from the preliminary DSM-IV criteria is that the minimum average frequency of binge eating required for diagnosis has been changed from at least twice weekly for 6 months to **at least once weekly over the last 3 months**.
  - Identical to the DSM-5 frequency criterion for bulimia nervosa.

Key Points:
Feeding and Eating Disorders

- Binge eating disorder has been added as a diagnosis for individuals who have persistent episodes, at least once a week, of overeating marked by loss of control and significant clinical distress.
- Criteria for anorexia have been amended, eliminating the requirement for amenorrhea.
- DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been broadened.
- Criteria for bulimia nervosa now require a minimum average frequency for binge eating and inappropriate compensatory behavior of once weekly. (DSM-IV criteria required twice weekly.)

Elimination Disorders

- The disorders in this chapter were previously classified under disorders usually first diagnosed in infancy, childhood, or adolescence in DSM-IV and exist now as an independent classification in DSM-5.
- No significant changes have been made to the elimination disorders diagnostic class from DSM-IV to DSM-5.

Sleep-Wake Disorders

1. Insomnia Disorder
2. Hypersomnolence Disorder
3. Narcolepsy

Breathing-Related Sleep Disorders

1. Obstructive Sleep Apnea Hypopnea Syndrome
2. Central Sleep Apnea
3. Sleep-Related Hypoventilation
4. Circadian Rhythm Sleep-Wake Disorders

Parasomnias

1. Non–Rapid Eye Movement Sleep Arousal Disorders
    - Sleepwalking
    - Sleep Terrors
2. Nightmare Disorder
3. Rapid Eye Movement Sleep Behavior Disorder
4. Restless Legs Syndrome
5. Substance/Medication-Induced Sleep Disorder
6. Other Specified Insomnia Disorder
7. Unspecified Insomnia Disorder
8. Other Specified Hypersomnolence Disorder
9. Unspecified Hypersomnolence Disorder
10. Other Specified Sleep-Wake Disorder
11. Unspecified Sleep-Wake Disorder

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Sleep-Wake Disorders

- DSM-5 moves away from making causal attributions between sleep-wake and coexisting medical and mental disorders.
- A sleep disorder may warrant independent clinical attention, in addition to any medical and mental disorders that are also present
  - Acknowledging the bidirectional and interactive effects between sleep disorders and coexisting medical and mental disorders.

Sleep-Wake Disorders

- Primary insomnia renamed insomnia disorder
  - Rationale: This name change better reflects the bidirectional relationships between insomnia and concurrent medical disorders, rather than implying a causal relationship.

Sleep-Wake Disorders

- Rapid eye movement sleep behavior disorder and restless legs syndrome both elevated to the main body of the manual
  - Rationale: Both of these disorders have ample data on clinical utility, polysomnography features, and treatment response to warrant promotion.

Circadian Rhythm Sleep Disorders

- Subtypes expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour type
  - Rationale: Inclusion of these subtypes was based on the presence of biomarkers, familial heritability, and public health need (e.g., significant impairment that can occur from chronic sleep deprivation; association with other psychiatric disorders).

Breathing-Related Sleep Disorders

- Specific diagnostic criteria are now provided for Obstructive Sleep Apnea Hypopnea, Central Sleep Apnea, and Sleep Related Hypoventilation
  - Rationale: As consistent with the *International Classification of Sleep Disorders*, this change is supported by literature suggesting differences in each disorder's physiological and anatomical pathogenesis and comorbidities.

Sleep-Wake Disorders

- DSM-5 distinguishes narcolepsy, which is now known to be associated with hypocretin deficiency, from other forms of hypersomnolence.

Sexual Dysfunctions

1. Delayed Ejaculation
2. Erectile Disorder
3. Female Orgasmic Disorder
4. Female Sexual Interest/Arousal Disorder
5. Genito-Pelvic Pain/Penetration Disorder
6. Male Hypoactive Sexual Desire Disorder
7. Premature (Early) Ejaculation
8. Substance/Medication-Induced Sexual Dysfunction
9. Other Specified Sexual Dysfunction
10. Unspecified Sexual Dysfunction

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- In DSM-IV, the chapter “Sexual and Gender Identity Disorders” included three relatively distinct diagnostic classes: gender identity disorders, sexual dysfunctions, and paraphilias.
- This chapter is now divided into three separate chapters:
  - **Sexual Dysfunctions**
  - **Gender Dysphoria**
  - **Paraphilic Disorders**

Sexual Dysfunctions

- In the Introduction, the Masters and Johnson conceptual model of the sexual response cycle has been abandoned.
- Premature (Early) Ejaculation has introduced a duration criterion of approximately 60 seconds.
- Female sexual desire and arousal disorders have been combined into one disorder: female sexual interest/arousal disorder.

Sexual Dysfunctions

Vaginismus and dyspareunia are merged into genito-pelvic pain/penetration disorder

> Rationale: These two DSM-IV disorders were highly comorbid and difficult to differentiate, resulting in poor clinical utility and reliability. Data suggest they likely represent overlapping features of a single condition.

To indicate the presence and degree of medical and nonmedical correlates, select associated features were added to text (e.g., partner factors, cultural or religious factors)

Sexual Dysfunctions

- Includes gender-specific sexual dysfunctions.
- Paraphillic disorders (previously included in the DSM-IV chapter titled “Sex and Gender Identity Disorders”) have been split off into a separate chapter.
- All of the DSM-5 sexual dysfunctions except substance-/medication-induced sexual dysfunction now require a minimum duration of approximately six months to improve precision regarding duration and severity criteria and to reduce the likelihood of overdiagnosis.

Gender Dysphoria

1. Gender Dysphoria
2. Other Specified Gender Dysphoria
3. Unspecified Gender Dysphoria

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Gender Dysphoria

- A new category—and separate chapter—for gender dysphoria emphasizes the phenomenon of "gender incongruence" rather than cross-gender identification.
- Gender dysphoria is now separate from the chapters on sexual dysfunctions and on paraphillic disorders.
- The category is reconceptualized as one overarching diagnosis with separate developmentally appropriate criteria sets for children and for adolescents and adults.

Gender Dysphoria

- In DSM-5, people whose gender at birth is contrary to the one they identify with will be diagnosed with gender dysphoria.
- This diagnosis is a revision of DSM-IV's criteria for gender identity disorder and is intended to better characterize the experiences of affected children, adolescents, and adults.

Gender Dysphoria

Newly added as a separate diagnostic class in DSM-5

- Rationale: This new diagnostic class reflects a change in the conceptualization of gender identity disorder' s (GID) defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification, as in DSM-IV.
- The name change responds to concerns from consumers and advocates that the term *gender identity disorder* was stigmatizing. The revised term is already familiar to clinicians working with these populations and better reflects the emotional component of the diagnostic criteria.

Gender Dysphoria

Criteria now include two separate sets for children and for adults/adolescents

- Rationale: Slight changes in the wording of criteria for children were necessary given developmental considerations. For example, some children might not verbalize the desire to be of another gender due to fear of social reprimand or if living in a household where such verbalizations lead to punishment.

Agenda

9:00 am	Introduction to the Workshop
9:15 am	History of Diagnostic Classification and Development of the DSM
10:00 am	Overall Changes: From DSM-IV-TR to DSM-5
10:15 am	BREAK
10:30 am	Specific Changes: Neurodevelopmental Disorders
11:00 am	Specific Changes: Schizophrenia Spectrum and Other Psychotic Disorders
11:30 am	Specific Changes: Bipolar and Depressive Disorders
12:00 pm	LUNCH
1:00 pm	Specific Changes: Anxiety, Obsessive-Compulsive, Trauma-Related, and Dissociative Disorder
1:45 pm	Specific Changes: Somatic Symptom, Eating, Sleep, and other Disorders
2:15 pm	**BREAK**
2:30 pm	Specific Changes: Impulse Control, Substance Use, Neurocognitive, and Personality Disorders
3:15 pm	Codes Issues and Insurance Implications
3:45 pm	Q & A
4:00 pm	ADJOURNMENT

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Disruptive, Impulse Control and Conduct Disorders

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Disruptive, Impulse-Control, and Conduct Disorders

1. Oppositional Defiant Disorder
2. Intermittent Explosive Disorder
3. Conduct Disorder
4. Antisocial Personality Disorder
5. Pyromania
6. Kleptomania
7. Other Specified Disruptive, Impulse-Control, and Conduct Disorder
8. Unspecified Disruptive, Impulse-Control, and Conduct Disorder

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Disruptive, Impulse-Control and Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Pyromania
- Kleptomania
- Other Specified [Disruptive, Impulse-Control, and Conduct Disorder]
- Unspecified [Disruptive, Impulse-Control, and Conduct Disorder]

Oppositional Defiant Disorder

- Other than separated from Neurodevelopmental Disorders, essentially unchanged (with anger, defiance, vindictiveness)
- For 5 years and older, behavior should occur at least once per week for at least 6 months
- Vindictiveness should be at least twice in six months
- If younger than 5, should occur on most days for at least 6 months
- Specifiers (Mild, moderate, severe)--mild allows symptoms in one setting

Intermittent Explosive Disorder

- Recurrent behavioral outbursts with verbal or physical aggression
- Twice weekly on average for three months
  - Physical aggression does not result in property damage or injury, and/or
- Three outbursts involving property damage or physical injury within 12 months
- Age at least 6 years (developmentally)
- Can be made in addition to ADHD, autism, ODD, CD

Conduct Disorder (CD)
(Disruptive, Impulse-Control, and Conduct Disorders)

Addition of a conduct disorder specifier called "with limited prosocial emotions"

- Rationale: Data have identified a subgroup of children with CD that display a lack of guilt and empathy, lack of concern over performance in important activities, and shallow affect. Compared to other children with CD, this subgroup appears to have more severe symptoms, a more stable course, and greater levels of aggression. Addition of this specifier will inform the development of specialized treatments separate from those used with other CD populations.

Intermittent Explosive Disorder (IED)

Provides more specific criteria to define types of outbursts and the frequency needed to meet threshold. Further, diagnosis is now limited to children at least 6 years of age.

- Rationale: More explicit criteria was needed to better differentiate IED from similar disorders of DMDD and CD, which also involve outbursts of aggressive or negative behavior. The addition of the age limit to children at least 6 years reflects the lack of research on IED in very young populations.

Other Specified Disruptive, Impulse-Control and Conduct Disorder

- This is used when the clinician chooses to communicate the reason the presentation does not meet criteria
- Example:
  - Other specified disruptive, impulse-control, and conduct disorder—recurrent behavioral outbursts of insufficient frequency
  - I would add what disorder you are close to….e.g. Insufficient frequency for intermittent explosive disorder

Unspecified Disruptive, Impulse-Control, and Conduct Disorder

- Situations where full criteria are not met
- Clinician chooses to not specify the reason that criteria are not met
- May be useful when there is insufficient information such as the emergency department.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Substance-Related and Addictive Disorders

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DSM-5 Substance-Related and Addictive Disorders

Substance-Related Disorders
- Substance Use Disorders
- Substance-Induced Disorders
- Substance Intoxication
- Substance Withdrawal
- Substance/Medication-Induced Disorders Included Elsewhere in the Manual

Alcohol-Related Disorders
- Alcohol Use Disorder
- Alcohol Intoxication
- Alcohol Withdrawal
- Unspecified Alcohol-Related Disorder
- Other Alcohol-Induced Disorders

Caffeine-Related Disorders
- Caffeine Intoxication
- Caffeine Withdrawal
- Unspecified Caffeine-Related Disorder
- Other Caffeine-Induced Disorders

Cannabis-Related Disorders
- Cannabis Use Disorder
- Cannabis Intoxication
- Cannabis Withdrawal
- Unspecified Cannabis-Related Disorder
- Other Cannabis-Induced Disorders

Hallucinogen-Related Disorders
- Phencyclidine Use Disorder
- Other Hallucinogen Use Disorder
- Phencyclidine Intoxication
- Other Hallucinogen Intoxication
- Hallucinogen Persisting Perception Disorder
- Unspecified Phencyclidine-Related Disorder
- Unspecified Hallucinogen-Related Disorder
- Other Phencyclidine-Induced Disorders
- Other Hallucinogen-Induced Disorders

Inhalant-Related Disorders
- Inhalant Use Disorder
- Inhalant Intoxication
- Unspecified Inhalant-Related Disorder
- Other Inhalant-Induced Disorders

Opioid-Related Disorders
- Opioid Use Disorder
- Opioid Intoxication
- Opioid Withdrawal
- Unspecified Opioid-Related Disorder
- Other Opioid-Induced Disorders

DSM-5 Substance-Related and Addictive Disorders

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal
- Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder
- Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders

Stimulant-Related Disorders
- Stimulant Use Disorder
- Stimulant Intoxication
- Stimulant Withdrawal
- Unspecified Stimulant-Related Disorder
- Other Stimulant-Induced Disorders

Tobacco-Related Disorders
- Tobacco Use Disorder
- Tobacco Withdrawal
- Unspecified Tobacco-Related Disorder

Other (or Unknown) Substance-Related Disorders
- Other (or Unknown) Substance Use Disorder
- Other (or Unknown) Substance Intoxication
- Other (or Unknown) Substance Withdrawal
- Unspecified Other (or Unknown) Substance-Related and Addictive Disorder
- Other (or Unknown) Substance-Induced Disorders

- Gambling Disorder

DSM-5: Diagnoses associated with substance class

	Psychotic disorders	Bipolar disorders	Depressive disorders	Anxiety disorders	Obsessive-compulsive and related disorders	Sleep disorders	Sexual dysfunctions	Delirium	Neurocognitive disorders	Substance use disorders	Substance intoxication	Substance withdrawal
Alcohol	I/W	I/W	I/W	I/W		I/W	I/W	I/W	I/W/P	X	X	X
Caffeine				I		I/W					X	X
Cannabis	I			I		I/W		I		X	X	X
Hallucinogens												
Phencyclidine	I	I	I	I				I		X	X	
Other hallucinogens	I*	I	I	I				I		X	X	
Inhalants	I		I	I				I	I/P	X	X	
Opioids			I/W	W		I/W	I/W	I/W		X	X	X
Sedatives, hypnotics, or anxiolytics	I/W	I/W	I/W	W		I/W	I/W	I/W	I/W/P	X	X	X
Stimulants**	I	I/W	I/W	I/W	I/W	I/W	I	I		X	X	X
Tobacco						W				X		X
Other (or unknown)	I/W	I/W	I/W	I/W	I/W	I/W	I/W	I/W	I/W/P	X	X	X

Note. X = The category is recognized in DSM-5. I = The specifier "with onset during intoxication" may be noted for the category. W = The specifier "with onset during withdrawal" may be noted for the category. I/W = Either "with onset during intoxication" or "with onset during withdrawal" may be noted for the category. P = The disorder is persisting. *Also hallucinogen persisting perception disorder (flashbacks). **Includes amphetamine-type substances, cocaine, and other or unspecified stimulants.

Substance Use Disorder (SUD)
(Substance-Related and Addictive Disorders)

Consolidate substance abuse with substance dependence into a single disorder called substance use disorder and create a continuum that includes mild, moderate, or severe substance use.

- Rationale: *Dependence* is a misunderstood term that has negative connotations when in fact it refers to normal patterns of withdrawal that can occur from the proper use of medications.

Substance Use Disorder (cont'd)

Rationale continued:

- Studies from clinical and general populations indicate DSM-IV substance abuse and dependence criteria represent a singular phenomenon but encompassing different levels of severity.
- Mild SUD (2-3/11 criteria) will be coded with the DSM-IV substance abuse code. Moderate (4-5/11 criteria) and severe (6+/11 criteria) SUD will be coded with DSM-IV substance dependence codes.

Substance Use Disorder (cont'd)

Removal of one of the DSM-IV abuse criteria (legal consequences), and addition of a new criterion for SUD diagnosis (craving or strong desire or urge to use the substance)

- Rationales: The legal criterion had poor clinical utility and its relevance to patients varied based on local laws and enforcement of those laws. Addition of craving as a symptom is highly validated, based on clinical trials and brain imaging data, and may hold potential as a future biomarker for the diagnosis of SUD.

Substance Use Disorder (cont'd)

- Group gambling disorder with substance use disorders
- Add cannabis withdrawal.
- Add to Section 3:
  - Internet Gaming Disorder.
  - Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure
  - Caffeine Use Disorder

Substance Use and Addictive Disorders

- Chapter order and numbering designations have been reorganized according to substance (whereas these were previously organized according to the diagnosis [i.e., use, intoxication, withdrawal])
- Phencyclidine Disorders are now under Hallucinogen Disorders
- Sedative/Hypnotic-Related Disorders renamed from Sedative, Hypnotic, or Anxiolytic Disorders
- Amphetamine and Cocaine Disorders renamed Stimulant Disorders
- Updated the Severity Specifiers
- Updated the Remission Specifiers
- Removal of Substance-Induced Dissociative Disorder

Substance Use and Addictive Disorders

- DSM-IV diagnosis of polysubstance dependence has been eliminated because it wasn't clinically useful.
  - So many substance abusers use more than one substance, and gamblers often have accompanying problems with alcohol or drugs.

Substance Use and Addictive Disorders

- Minor wording changes to most of the criteria
- Addition of criteria for Hallucinogen Persisting Perception Disorder
- Addition of criteria for Drug Specific "Not Elsewhere Classified" diagnoses

DSM-IV and DSM-5 Criteria for Substance Use Disorders

	DSM-IV Abuse[a]		DSM-IV Dependence[b]		DSM-5 Substance Use Disorders[c]	
Hazardous use	X	≥1 criterion	–		X	≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal[d]	–		X	≥3 criteria	X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

[a] One or more abuse criteria within a 12-month period *and* no dependence diagnosis; applicable to all substances except nicotine, for which DSM-IV abuse criteria were not given.
[b] Three or more dependence criteria within a 12-month period.
[c] Two or more substance use disorder criteria within a 12-month period.
[d] Withdrawal not included for cannabis, inhalant, and hallucinogen disorders in DSM-IV. Cannabis withdrawal added in DSM-5.

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Substance Use and Addictive Disorders

- Addition of a new category of “behavioral addictions” which contains a single disorder: gambling addiction.
- “Internet addiction was considered for this category, but there was insufficient research data to do so, so they it will be included in the manual’s appendix instead.

Gambling Disorder in DSM-5

- Gambling disorder in *DSM-5*, replaces pathological gambling in the "Impulse-Control Disorders Not Elsewhere Classified" section of earlier editions.
- Inclusion of gambling with substance-related disorders reflects research evidence showing that reward-related neurocircuitry and behavior patterns of addictive gambling are similar to those of substance-related addictions.

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Neurocognitive Disorders

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Neurocognitive Disorders

1. Delirium
2. Other Specified Delirium
3. Unspecified Delirium
4. Major & Mild Neurocognitive Disorders
5. Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease
6. Major or Mild Frontotemporal Neurocognitive Disorder
7. Major or Mild Neurocognitive Disorder with Lewy Bodies
8. Major or Mild Vascular Neurocognitive Disorder
9. Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury
10. Substance/Medication-Induced Neurocognitive Disorder
11. Major or Mild Neurocognitive Disorder Due to HIV Infection
12. Major or Mild Neurocognitive Disorder Due to Prion Disease
13. Major or Mild Neurocognitive Disorder Due to Parkinson's Disease
14. Major or Mild Neurocognitive Disorder Due to Huntington's Disease
15. Neurocognitive Disorder Due to Another Medical Condition
16. Major or Mild Neurocognitive Disorder Due to Multiple Etiologies
17. Unspecified Neurocognitive Disorder

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Neurocognitive Disorders

- Neurocognitive Disorders replace the DSM-IV Category of Delirium, Dementia, Amnestic, and Other Geriatric Cognitive Disorders.
- The defining characteristics of these disorders are that their core or primary deficits are in cognition and that these deficits represent a decline from a previously attained level of cognitive functioning
  - distinguishing them from the neurodevelopmental disorders in which a neurocognitive deficit is present at birth or interferes with development.
- This section includes three broadly defined syndromes.

  (1) Delirium,

  (2) Major Neurocognitive Disorder

  (3) Minor Neurocognitive Disorder

Neurocognitive Disorders

- Use of term neurocognitive disorder rather than dementia
- Addition of mild neurocognitive disorder as a new disorder
- Elevation of DSM-IV etiological subtypes (e.g., frontotemporal dementia, Dementia with Lewy Bodies) to separate, independent disorders
  - Separate criteria within each of these for “probable” versus “possible” etiology

Neurocognitive Disorders

- The distinction between Major and Minor disorders is primarily one of severity, with the threshold for Major Neurocognitive Disorder encompassing a greater degree of cognitive impairment and hence a loss of independence in instrumental activities of daily living.
- In most progressive disorders such as the neurodegenerative disorders and some forms of vascular cognitive impairment, Minor and Major may be earlier and later stages of the same disorder.
  - In these settings, the differences may involve impairment in additional cognitive domains as well as more severe impairment within the domains as the patient crosses from the Minor to Major level of impairment.

Neurocognitive Disorders (NCD)

Use of the term *major neurocognitive disorder* rather than *dementia*

- Rationale: The term *dementia* is usually associated with neurodegenerative conditions occurring in older populations, as in Alzheimer's disease and Lewy Body dementia. However, DSM-5's major NCD refers to a broad range of possible etiologies that can occur even in young adults, such as major NCD due to traumatic brain injury or HIV infection.

Mild NCD

Newly added to DSM-5

- Rationale: Patients with mild NCD are frequently seen in clinics and in research settings, and there is widespread consensus throughout the field that these populations can benefit from diagnosis and treatment. The clinical utility of such a diagnosis also is highly supported in the literature.

NCD Subtypes

Elevation of DSM-IV etiological subtypes (e.g., frontotemporal dementia, dementia with Lewy Bodies) to separate, independent disorders

- Rationale: Separate criteria for 10 etiologies were developed based on clinical need and to reflect the best clinical practices endorsed by neurologists, neuro-psychiatrists, and others who routinely work with these patients. Etiological criteria provide clarity for clinicians, more accurate diagnoses for patients, and support for researchers in uncovering potential biomarkers that may inform diagnosis in the future.

Subclassification by Etiology

Major or Mild Neurocognitive Disorder Due to:

1. Alzheimer's disease
2. Lewy body Disease
3. Frontotemporal neurocognitive impairment
4. Vascular neurocognitive impairment
5. Traumatic brain injury
6. HIV
7. Huntington's disease
8. Prion Disease
9. Substance use disorders
10. Parkinson's Disease

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Specific Changes in Diagnostic Criteria:

Personality Disorders

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Personality Disorders

1. Paranoid Personality Disorder
2. Schizoid Personality Disorder
3. Schizotypal Personality Disorder
4. Antisocial Personality Disorder
5. Borderline Personality Disorder
6. Histrionic Personality Disorder
7. Narcissistic Personality Disorder
8. Avoidant Personality Disorder
9. Dependent Personality Disorder
10. Obsessive-Compulsive Personality Disorder
11. Personality Change Due to Another Medical Condition
12. Other Specified Personality Disorder
13. Unspecified Personality Disorder

Personality Disorders

- Axis II has been eliminated.
- DSM-5 will maintain the categorical model and criteria for the ten personality disorders included in DSM-IV.

Personality Disorders (PD)

Section III contains an alternate, trait-based approach to assessing personality and PDs that includes specific PD types (e.g., borderline, antisocial) but allows for the rating of traits and facets, facilitating diagnosis in individuals who meet core criteria for a PD but do not otherwise meet a specific PD type.

- Rationale: A hybrid model with both dimensional and categorical approaches is included in Section III. This model calls for evaluation of impairments in personality functioning and characterizes five broad areas of pathological personality traits. It identifies six PD types, each defined by both impairments in personality functioning and a pattern of impairments in personality traits. We will evaluate the strengths and weaknesses of the model, leading to greater understanding of the causes and treatments of PDs.

To create an individualized, person-centered approach, the DSM-5 would include a four part assessment of personality,

1. ***Severity scale.*** Rated from zero (no impairment) to four (extreme impairment)
2. ***Type match.*** To what degree does a patient's personality match one of the five remaining personality types, from one (no match) to five (a good match)
3. ***Trait domains and facets.*** Each personality type may have up to six "trait domains"—negative emotionality, introversion, antagonism, disinhibition, compulsivity, and schizotypy. Each trait domain is further broken down to more specific "trait facets."
   - Rate each trait on a scale from zero (not at all descriptive) to three (extremely descriptive)
4. ***Personality disorder.*** Finally, you determine: "Does the person meet criteria for a personality disorder?"

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Paraphilic Disorders

Chapter title and content emphasize paraphilic disorders rather than paraphilias

- Rationale: Paraphilias that do not involve non-consenting victims (e.g., transvestism) are not necessarily indicative of a mental disorder. To have a paraphilic disorder requires distress, impairment, or abuse of a non-consenting victim.

Paraphilic Disorders

"In a controlled environment" and "in remission" specifiers added to all paraphilic disorders

- Rationale: These new specifiers reflect important aspects of clinical status that may impact symptom presentation. For instance, opportunities to engage in paraphilic disorder behaviors may be limited if the individual is in an institutional setting or other controlled environment.

DSM-5

Classification, Criteria, and Use

Optional Section III Measures
Recommended for
Further Study and Evaluation

Optional Measurements in DSM-5

- Assess patient characteristics not necessarily included in diagnostic criteria but of high relevance to prognosis, treatment planning and outcome for most patients
- In DSM-5, these include:
  - Level 1 and Level 2 Cross-Cutting Symptom assessments
  - Diagnosis-specific Severity ratings
  - Disability assessment
- May be patient, informant, or clinician completed, depending on the measure

Emerging Assessment Measures

- Developed to be administered at the initial patient interview and to monitor treatment progress, thus serving to advance the use of initial symptomatic status and patient reported outcome (PRO) information, as well as the use of “anchored” severity assessment instruments.
- Instructions, scoring information, and interpretation guidelines are included.

Emerging Assessment Measures

1. **Cross-cutting symptom measures** may aid in a comprehensive mental status assessment by drawing attention to symptoms that are important across diagnoses:
   a. Level 1 questions- a brief survey of 13 domains for adult patients and 12 domains for C&A patients
   b. Level 2 questions- a more in-depth assessment of certain domains
2. **Severity measures** are disorder-specific, corresponding closely to criteria that constitute the disorder definition.
   - They may be administered to individuals who have received a diagnosis or who have a clinically significant syndrome that falls short of meeting full criteria.
   - Some of the assessments are self-completed, whereas others require a clinician to complete.

Emerging Assessment Measures

3. **The WHO Disability Assessment Schedule** (WHODAS 2.0) assesses a patient's ability to perform activities in six areas: understanding and communicating; getting around; self-care; getting along with people; life activities; and participation in society.
   - The scale is self- or informant-administered and corresponds to concepts contained in the WHO International Classification of Functioning, Disability and Health.
4. **The Personality Inventories for DSM-5** measure maladaptive personality traits in five domains: negative affect, detachment, antagonism, disinhibition, and psychoticism.
   - For adults and children ages 11 and older, there are brief forms with 25 items and full versions with 220 items. A full version for informants is also available.

Level 1 Cross-Cutting Symptom Measure

- Referred to as "cross-cutting" because it calls attention to symptoms relevant to most, if not all, psychiatric disorders (e.g., mood, anxiety, sleep disturbance, substance use, suicide)
  - Self-administered by patient
  - 13 symptom domains for adults
  - 12 symptoms domains for children 11+, parents of children 6+
  - Brief—1-3 questions per symptom domain
  - Screen for important symptoms, not for specific diagnoses (i.e., "cross-cutting")

Patient-Rated Level 1 Cross-Cutting Measure

Note: The following questions inquire about how you have been feeling over the past two weeks.

During the past 2 weeks, how much have you been bothered by the following problems:	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3	4
2. Feeling down, depressed, or hopeless?	0	1	2	3	4
3. Feeling irritated, grouchy, angry?	0	1	2	3	4
4. Sleeping less but still having a lot of energy?	0	1	2	3	4
5. Starting lots of projects or doing more risky things?	0	1	2	3	4
6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
7. Feeling panic or being frightened?	0	1	2	3	4
8. Avoiding situations that make you anxious?	0	1	2	3	4
9. Having unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	0	1	2	3	4
10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4

Patient-Rated Level 1 Cross-Cutting Measure

Note: The following questions inquire about how you have been feeling over the past two weeks.

During the past 2 weeks, how much have you been bothered by the following problems:	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
11. Having thoughts of actually hurting yourself?	0	1	2	3	4
12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
13. Feeling that someone could hear your thoughts or that you could hear what another person was thinking?	0	1	2	3	4
14. Having problems with sleep that affected your sleep quality over all?	0	1	2	3	4
15. Having problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
16. Having unpleasant thoughts, images, or urges that repeatedly enter your mind?	0	1	2	3	4
17. Feeling driven to perform certain acts over and over again?	0	1	2	3	4
18. Not knowing who you really are or what you want out of life?	0	1	2	3	4
19. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
20. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
21. Smoking any cigarettes, a cigar, or pipe or using snuff or chewing tobacco?	0	1	2	3	4
22. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4

Level 2 Cross-Cutting Measure

- Completed when the corresponding Level 1 item is endorsed at the level of “mild” or greater (for most but not all items, i.e., psychosis and inattention)
  - Gives a more detailed assessment of the symptom domain
  - Largely based on pre-existing, well-validated measures, including the SNAP-IV (inattention); NIDA-modified ASSIST (substance use); and PROMIS® forms (anger, sleep disturbance, emotional distress)

Example of a Level 2 Cross-cutting Assessment: Sleep

Please respond to each item by choosing one option per question.					
In the past SEVEN (7) DAYS....	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was restless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
I was satisfied with my sleep.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
My sleep was refreshing.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
I had difficulty falling asleep.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
In the past SEVEN (7) DAYS....	Never	Rarely	Sometimes	Often	Always
I had trouble staying asleep.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
I had trouble sleeping.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
I got enough sleep.	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
In the past SEVEN (7) DAYS…	Very Poor	Poor	Fair	Good	Very good
My sleep quality was...	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

LEVEL 2—Depression—Adult*

*PROMIS Emotional Distress—Depression—Short Form

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "no interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt worthless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt that I had nothing to look forward to.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt helpless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt like a failure.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt depressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	I felt hopeless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Substance Use—Adult*

*Adapted from the NIDA-Modified ASSIST

During the past **TWO (2) WEEKS**, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?							**Clinician Use**
		Not at all	**One or two days**	**Several days**	**More than half the days**	**Nearly every day**	**Item Score**
a.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
b.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Or drugs like:							
d.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
e.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
f.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
g.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
h.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
i.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
j.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total Score:	

Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: 13 domains, thresholds for further inquiry, and associated DSM-5 Level 2 measures

Domain	Domain name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure[a]
I.	Depression	Mild or greater	Level 2—Depression—Adult (PROMIS Emotional Distress—Short Form)
II.	Anger	Mild or greater	Level 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)
III.	Mania	Mild or greater	Level 2—Mania—Adult (Altman Self-Rating Mania Scale [ASRM])
IV.	Anxiety	Mild or greater	Level 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)
V.	Somatic symptoms	Mild or greater	Level 2—Somatic Symptom—Adult (Patient Health Questionnaire–15 [PHQ-15] Somatic Symptom Severity Scale)
VI.	Suicidal ideation	Slight or greater	None
VII.	Psychosis	Slight or greater	None
VIII.	Sleep problems	Mild or greater	Level 2—Sleep Disturbance—Adult (PROMIS Sleep Disturbance—Short Form)
IX.	Memory	Mild or greater	None
X.	Repetitive thoughts and behaviors	Mild or greater	Level 2—Repetitive Thoughts and Behaviors—Adult (Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale)
XI.	Dissociation	Mild or greater	None
XII.	Personality functioning	Mild or greater	None
XIII.	Substance use	Slight or greater	Level 2—Substance Use—Adult (adapted from the NIDA-Modified ASSIST)

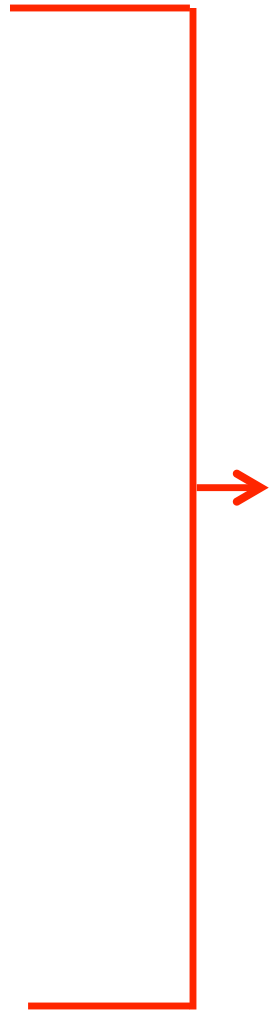
Note. NIDA = National Institute on Drug Abuse. [a]Available at www.psychiatry.org/dsm5.

Diagnosis-Specific Severity Measures

- For documenting the severity of a specific disorder using, for example, the frequency and intensity of its component symptoms
- Can be administered to individuals with:
  - A diagnosis meeting full criteria
  - An “other specified” diagnosis, esp. a clinically significant syndrome that does not meet diagnostic threshold
- Some clinician-rated, some patient-rated

Diagnosis-Specific Severity Assessment: Symptom Domains for Schizophrenia

- Hallucinations
- Delusions
- Disorganized Speech
- Abnormal Psychomotor Beh
- Negative Symptoms
  (Restricted Emotional Expression or Avolition)
- Impaired Cognition
- Depression
- Mania



0 = Not Present

1 = Equivocal

2 = Present, but mild

3 = Present and moderate

4 = Present and severe

Clinician-Rated Dimensions of Psychosis Symptom Severity

Name:_____ **Age:** _____ **Sex: [ ] Male [ ] Female** **Date:**_____

Instructions: Based on all the information you have on the individual and using your clinical judgment, please rate (with checkmark) the presence and severity of the following symptoms as experienced by the individual in the past seven (7) days.

Domain	0	1	2	3	4	Score
I. Hallucinations	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon voices, not very bothered by voices)	❑ Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices)	❑ Present and severe (severe pressure to respond to voices, or is very bothered by voices)	
II. Delusions	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs)	❑ Present and moderate (some pressure to act upon beliefs, or is somewhat bothered by beliefs)	❑ Present and severe (severe pressure to act upon beliefs, or is very bothered by beliefs)	
III. Disorganized speech	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered disorganization)	❑ Present, but mild (some difficulty following speech)	❑ Present and moderate (speech often difficult to follow)	❑ Present and severe (speech almost impossible to follow)	
IV. Abnormal psychomotor behavior	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)	❑ Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)	❑ Present and moderate (frequent abnormal or bizarre motor behavior or catatonia)	❑ Present and severe (abnormal or bizarre motor behavior or catatonia almost constant)	
V. Negative symptoms (restricted emotional expression or avolition)	❑ Not present	❑ Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present, but mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and severe decrease in facial expressivity, prosody, gestures, or self-initiated behavior	
VI. Impaired cognition	❑ Not present	❑ Equivocal (cognitive function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean)	❑ Present, but mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean)	❑ Present and moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean)	❑ Present and severe (severe reduction in cognitive function; below expected for age and SES, > 2 SD from mean)	
VII. Depression	❑ Not present	❑ Equivocal (occasionally feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied)	❑ Present, but mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation)	❑ Present and moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong)	❑ Present and severe (deeply depressed or hopeless daily; delusional guilt or unreasonable self-reproach grossly out of proportion to circumstances)	
VIII. Mania	❑ Not present	❑ Equivocal (occasional elevated, expansive, or irritable mood or some restlessness)	❑ Present, but mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness)	❑ Present and moderate (frequent periods of extensively elevated, expansive, or irritable mood or restlessness)	❑ Present and severe (daily and extensively elevated, expansive, or irritable mood or restlessness)	

Note. SD = standard deviation; SES = socioeconomic status.

Emerging Assessment Measures

These measures should be used to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis.

Further information on these measures can be found in DSM-5.

http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

World Health Organization Disability Assessment Schedule (WHODAS 2.0)

- WHODAS 2.0 is the recommended, but not required, assessment for disability
- Corresponds to disability domains of ICF
- Developed for use in all clinical and general population groups
- Tested world-wide and in DSM-5 Field Trials
- 36 questions, self-administered with clinician review
- For Adult Patients
  - Child version developed by DSM-5, not yet approved by WHO

WHODAS Domains

- Understanding and communicating
- Getting around
- Self Care
- Getting along with people
- Life activities
  - household
  - work or school
- Participation in Society

From DSM-IV-TR to DSM-5

What Specifically is Changing?

Code Issues and Insurance Implications

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New DSM-5 Diagnoses Code Issues

- Dual coding provided to account for lag between DSM-5's publication and official implementation of ICD-10-CM codes (October 1, 2014)
- Codes accompany each criteria set
  - Some codes are used for multiple disorders
- In select places, unique codes are given for subtypes, specifiers, and severity
- For neurocognitive and substance/medication-induced disorders, coding depends on further specification

New DSM-5 Diagnoses Code Issues

DSM-5 Disorder	ICD-9-CM Code	ICD-9-CM Title	ICD-10-CM Code	ICD-10-CM Title
Social (Pragmatic) Communication Disorder	315.39	Other developmental speech or language disorder	F80.89	Other developmental disorders of speech and language
Disruptive Mood Dysregulation Disorder	296.99	Other Specified Episodic Mood Disorder	F34.8	Other Persistent Mood [Affective] Disorder
Premenstrual Dysphoric Disorder (from DSM-IV appendix)	625.4	Premenstrual tension syndromes	N94.3	Premenstrual tension syndrome

New DSM-5 Diagnoses Code Issues

DSM-5 Disorder	ICD-9-CM Code	ICD-9-CM Title	ICD-10-CM Code	ICD-10-CM Title
Hoarding Disorder	300.3	Obsessive Compulsive Disorders	F42	Obsessive Compulsive Disorder
Excoriation (Skin Picking) Disorder	698.4	dermatitis factitia [artefacta]	L98.1	factitial dermatitis
Binge Eating Disorder (from DSM-IV Appendix)	307.51	bulimia nervosa	F50.2	bulimia nervosa
Substance Use Disorders	Coding will be applied based on severity: ICD codes associated with substance abuse will be used to indicated mild SUD; ICD codes associated with substance dependence will be used to indicate moderate or severe SUD			

New DSM-5 Diagnoses Code Issues

- When using these DSM-5 diagnoses, clinicians should note the name of the disorder next to the code listing, since no distinct code yet exists for these diagnoses.
- The APA is working with insurers to ensure these are recognized as distinct entities.

Important Insurance Considerations

- There may be some delay for certain insurance carriers to update their coding systems
- Similar delays may exist for removing the multiaxial format from forms and computer systems
  - Place all mental and other medical disorders on a single list—with ICD code and name of disorder
  - In place of Axis IV, use DSM-5's v/z/t codes
  - WHODAS 2.0 provided for disability rating (formerly Axis V), but no replacement for the GAF has been approved as of yet

For more information about CMS acceptance of DSM-IV and ICD-9-CM codes, visit their online FAQ at: https://questions.cms.gov/faq.php?id=5005&faqId=1817

Frequently Asked Questions Pertinent to Insurers and Clinicians

http://www.dsm5.org/Documents/Insurance%20Implications%20of%20DSM-5--FAQ%205-14-13.pdf
Accessed May 29, 2013

Insurance Implications of DSM-5

When can DSM-5 be used for insurance purposes?

- Since DSM-5 is completely compatible with the HIPAA-approved ICD-9-CM coding system now in use by insurance companies, the revised criteria for mental disorders can be used immediately for diagnosing mental disorders when it is released in May 2013. However, the change in format from a multi-axial system in DSM-IV-TR may result in a brief delay while insurance companies update their claim forms and reporting procedures to accommodate DSM-5 changes.

Insurance Implications of DSM-5

How will the previous multi-axial conditions be coded?

DSM-5 combines the first three DSM-IV-TR axes into one list that contains all mental disorders, including personality disorders and intellectual disability, as well as other medical diagnoses. Although a single axis recording procedure was previously used for Medicare and Medicaid reporting, some insurance companies required clinicians to report on the status of all five DSM-IV-TR axes.

Contributing psychosocial and environmental factors or other reasons for visits are now represented through an expanded selected set of ICD-9-CM V-codes and, from the forthcoming ICD-10-CM, Z-codes. These codes provide ways for clinicians to indicate other conditions or problems that may be a focus of clinical attention or otherwise affect the diagnosis, course, prognosis, or treatment of a mental disorder (such as relationship problems between patients and their intimate partners). These conditions may be coded along with the patient's mental and other medical disorders if they are a focus of the current visit or help to explain the need for a treatment or test. Alternatively, they may be entered into the patient's clinical record as useful information on circumstances that may affect the patient's care.

Insurance Implications of DSM-5

On October 1, 2014, the United States adopts ICD-10-CM as its standard coding system. How will diagnoses be coded then?

DSM-5 contains both ICD-9-CM codes for immediate use and ICD-10-CM codes in parentheses. The inclusion of ICD-10-CM codes facilitates a cross-walk to the new coding system that will be implemented on October 1, 2014 for all U.S. health care providers and systems, as recommended by the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC-NCHS) and the Centers for Medicare and Medicaid Services (CMS). This feature will eliminate the need for separate training on ICD-10-CM codes for mental disorders that is now being offered for all other diseases/disorders by other medical societies and vendors to prepare for the 2014 implementation.

Insurance Implications of DSM-5

With the removal of the multiaxial system in DSM-5, how will disability and functioning be assessed? The DSM-5 includes separate measures of symptom severity and disability for individual disorders, rather than the Global Assessment of Functioning (GAF) scale that combined assessment of symptom severity, suicide risk, and social functioning into a single global assessment. This change is consistent with WHO recommendations to move toward a clear conceptual distinction between the disorders contained in the ICD and the disabilities resulting from disorders, which are described in the International Classification of Functioning, Disability, and Health (ICF).

The World Health Organization Disability Assessment Schedule (WHO-DAS 2.0) is provided in Section III of DSM-5 as the best current alternative for measuring disability, and various disorder-specific severity scales are included in Section III and online. The WHO-DAS 2.0 is based on the ICF and is applicable to patients with any health condition, thereby bringing DSM-5 into greater alignment with other medical disciplines. While the WHO-DAS was tested in the DSM-5 field trials and found to be reliable, it is not yet being recommended by APA until more data are available to evaluate its utility in assessing disability status for treatment planning and monitoring purposes.

Sometimes different disorders or subtypes share the same diagnostic code. Is this an error?

- No. It is occasionally necessary to use the same code for more than one disorder. Because the *DSM-5* diagnostic codes are limited to those contained in the *ICD*, some disorders must share codes for recording and billing purposes. For example, hoarding disorder and obsessive-compulsive disorder share the same codes (ICD-9-CM 300.3 and ICD-10-CM F42).
- Because there may be multiple disorders associated with a given ICD-9-CM or ICD-10-CM code, the DSM-5 diagnosis should be always be recorded by name in the medical record in addition to listing the code.

Insurance Implications of DSM-5

The names of some DSM-5 disorders do not match the names of the ICD disorders, even though the code is the same. Can you explain this?

- Because the DSM-5 diagnostic codes are limited to those contained in the ICD, new DSM-5 disorders were assigned the best available ICD codes. The names connected with these ICD codes sometimes do not match the DSM-5 names. For example, DSM-5 disruptive mood dysregulation disorder (DMDD) is not listed in the ICD. The best ICD-9-CM code available for DSM-5 use was 296.99 (other specified episodic mood disorder). For ICD-10-CM the code will be F34.8 (other persistent mood [affective] disorders). Please refer to the table below for other examples. APA will be working with CDC-NCHS and CMS to include new DSM-5 terms in the ICD-10-CM, and will inform clinicians and insurance companies when modifications are made.
- Because DSM-5 and ICD disorder names may not match, the DSM-5 diagnosis should always be recorded by name in the medical record in addition to listing the code.

DSM-5 Disorder	DSM-5/ICD-9-CM Code (in use through September 30, 2014)	ICD-9-CM Title	DSM-5/ICD-10-CM Code (in use starting October 1, 2014)	ICD-10-CM Title
Social (pragmatic) communication disorder	315.39	Other developmental speech or language disorder	F80.89	Other developmental disorders of speech and language
Disruptive mood dysregulation disorder	296.99	Other specified episodic mood disorder	F34.8	Other persistent mood [affective] disorders
Premenstrual dysphoric disorder	625.4	Premenstrual tension syndromes	N94.3	Premenstrual tension syndrome
Hoarding disorder	300.3	Obsessive-compulsive disorders	F42	Obsessive-compulsive disorder
Other specified obsessive compulsive and related disorder	300.3	Obsessive-compulsive disorders	F42	Obsessive-compulsive disorder
Unspecified obsessive compulsive and related disorder	300.3	Obsessive-compulsive disorders	F42	Obsessive-compulsive disorder
Excoriation (skin picking) disorder	698.4	Dermatitis factitia [artefacta]	L98.1	Factitial dermatitis
Binge eating disorder	307.51	Bulimia nervosa	F50.8	Other eating disorders

Insurance Implications of DSM-5

- **How are *DSM-5* and *ICD* related?**
- *DSM-5* and the *ICD* should be thought of as companion publications. *DSM-5* contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The *ICD* contains the code numbers used in *DSM-5* and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies. The APA works closely with staff from the WHO, CMS, and CDC-NCHS to ensure that the two systems are maximally compatible.
- The following URL contains the CMS response to a Frequently Asked Question (FAQ) about the relationship between *DSM* and *ICD-9-CM*: (https://questions.cms.gov/faq.php?id=5005&faqId=1817). This response will be updated to reflect the transition to *DSM-5* as soon as it is released.

Insurance Implications of DSM-5

How is information from DSM-5 used?

DSM-5 is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. Clinicians use DSM-5 diagnoses to communicate with their patients and with other clinicians, and to request reimbursement from insurance organizations. DSM-5 diagnoses may also be used by public health authorities for compiling and reporting morbidity and mortality statistics.

Another important role of DSM is to establish diagnoses for research on mental disorders. Only by having consistent and reliable diagnoses can researchers determine the risk factors and causes for specific disorders, and determine their incidence and prevalence rates

Insurance Implications of DSM-5

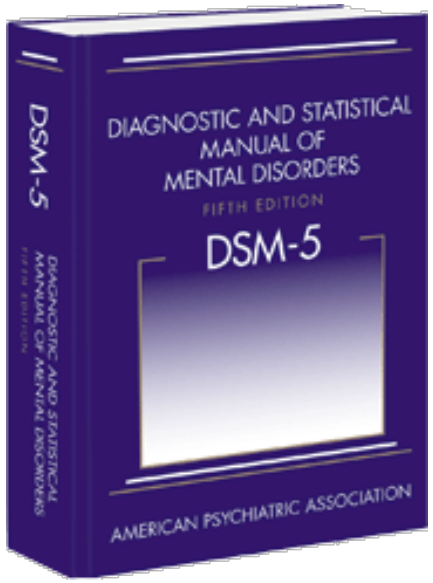
Can clinicians continue to use the DSM-IV-TR diagnostic criteria?

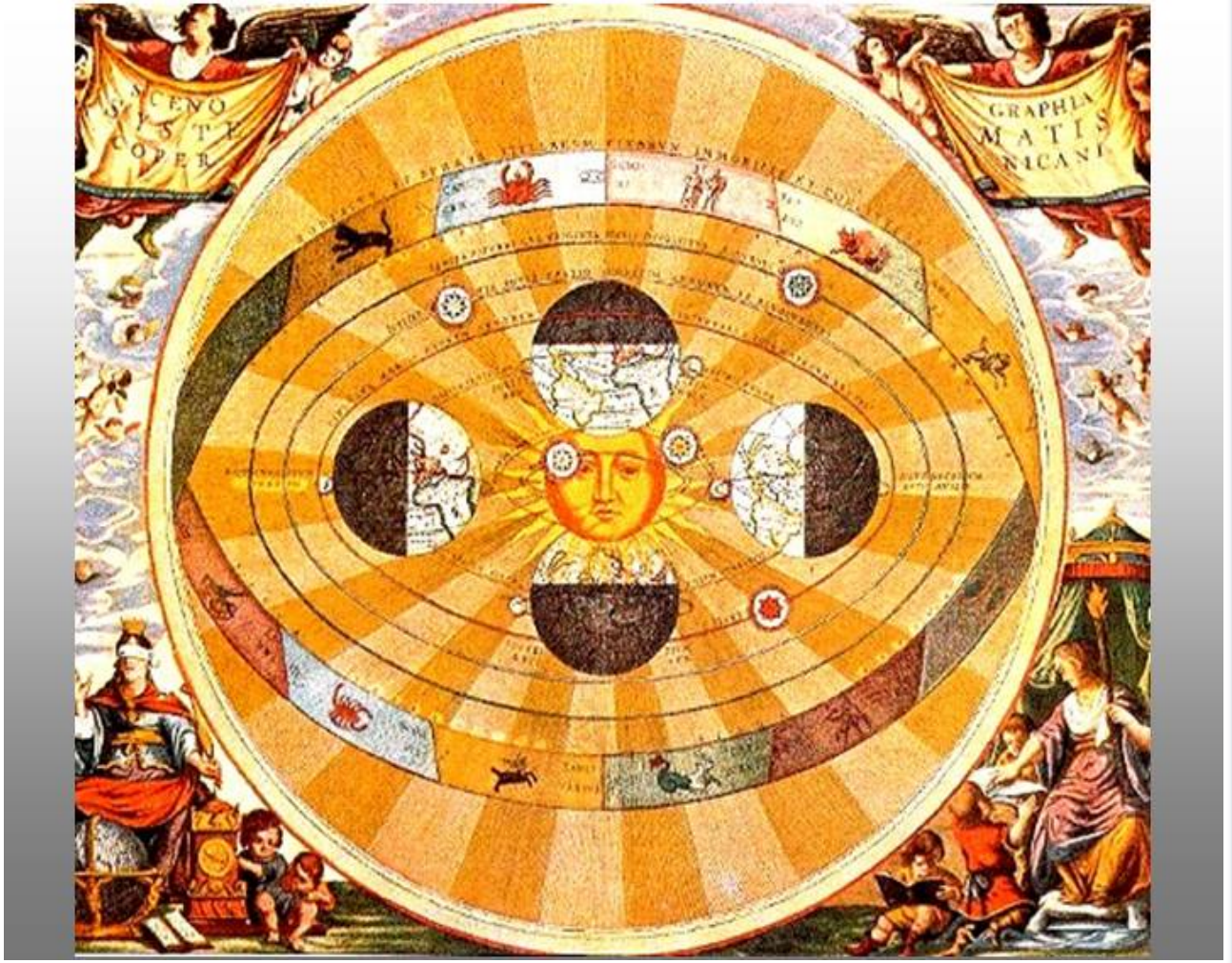
Clinicians may use DSM-5 in their practices starting in May, when the manual is released. However, there may be brief delays while insurance companies update their claim forms and reporting procedures to accommodate DSM-5 changes, and clinicians should use DSM-IV-TR diagnoses and codes when required by a specific company. Transition details are still being developed with CDC-NCHS, CMS, and private insurance agencies. The APA is working with these groups with the expectation that a transition to DSM-5 by the insurance industry can be made by December 31, 2013.

As part of the transition to DSM-5, there will also need to be updates of questions in board certification examinations and quality assessments for medical record reviews. APA will be providing periodic updates of agreements with federal agencies, private insurance companies, and medical examination boards as they become available.

From DSM-IV-TR to DSM-5

What Specifically is Changing?





Thanks